Treatment Date: _____ ***Periodontal Implant Center***

Post-Treatment Check: _____

Pre-Surgical Instructions

❑ Medications will be called in to the following pharmacy _____

**Please pick these up prior to the day of your surgery. *If Walgreens or CVS, you must voluntarily show your ID to be given any narcotic pain medicine.*

❑ You will need to be seen by your general dentist prior to surgery in our clinic for the following treatment _____

❑ **General Information**

1. Prior to the day of surgery, please pick up your medications at the pharmacy noted above.
2. Obtain a good night's sleep before surgery.
3. Continue any daily medications unless instructed otherwise.
4. Reduce or eliminate stimulants, particularly caffeine, the day of surgery.
5. Women should remove lipstick
6. Remove contact lenses
7. Remove jewelry (earrings, necklaces, etc…)
8. Remove black, brown, or dark blue nail polish
9. Wear a short-sleeved shirt or loose clothing
10. Please use the restroom immediately prior to surgery – there is a restroom located in the main entry to our office building

❑ **For Patients That Will Be Sedated (*Halcion Pill and/or Intravenous Sedation*)**

1. Follow *General Information* instructions above.
2. *Make sure to sign the *Patient Information and Consent Form* **prior** to taking any sedation medications *(Halcion or Phenergan)* and bring the signed consent form to your appointment.
3. Nothing to eat or drink 6 hours prior to surgery (*diabetics – individual instructions*).
4. Please take the Triazolam / Halcion medication as instructed on the bottle. Bring any remaining tablets to your appointment.
5. Someone must drive you to and from the office.
6. Plan to be accompanied for the remainder of the day after your treatment. You should not operate any vehicles/machinery or provide supervision to small children the rest of the day after treatment.

Note: Surgery time has been reserved especially for you. Any changes in your appointment time will delay completion of your treatment and will also affect many other patients. A fee may be charged for late cancellations (less than 4 business days).

(405) 636-1411 ❖ 8203 S. Walker Oklahoma City, OK 73139 ❖ Fax (405) 636-1197
Email: okperio@yahoo.com ❖ Web: www.okperio.com

PERIODONTAL IMPLANT CENTER

Practice Limited to Periodontal Therapy and Dental Implants

PATIENT INFORMATION AND CONSENT FORM

Patient's Name: _____

1. I have been informed and understand the purpose and nature of the recommended procedure. I request and authorize the recommended treatment.
2. To the best of my knowledge, I have given an accurate report of my physical and mental health history. I have reported any prior allergic or unusual reactions to drugs, foods or anesthetics and reported any previous episodes of abnormal bleeding or any other conditions related to my health.
3. I understand that there are alternatives to the recommended treatment, which include no treatment.
4. I understand that if treatment is declined and not completed, the following could occur: bone disease, loss of jawbone, gum tissue inflammation, infection, sensitivity of teeth, looseness of teeth, drifting of teeth and possible loss of teeth / necessity of extraction.
5. I agree to the type of anesthesia. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.
6. I understand the possible risks and complications involved with dental surgery, the use of dental anesthesia and pre/post-treatment medications. Such complications can include pain, swelling, infection, and discoloration of facial and/or oral tissues. Numbness of the lip, tongue, chin, cheek, or teeth can occur. Also possible are the injury to existing teeth, jawbone fractures, sinus penetration, delayed healing, allergic reactions to medications used during and/or post-treatment, temporomandibular joint (jaw) problems, headaches, referred pain to the muscles of the neck / face. For any patient undergoing intravenous sedation, inflammation of a vein is also possible. The exact duration of any of these adverse outcomes cannot be determined in advance and may be irreversible.
7. I understand that during the recommended procedure, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatments that are required to achieve the best outcome. I approve, in advance of treatment, any modification in design, materials, or additional therapies, if they are determined to be in my best interests.
8. I understand there is no method to accurately predict healing capabilities following dental surgery and/or the placement of a dental implant.
9. I understand that surgical outcomes cannot be guaranteed and in some instances teeth or implants must be removed following treatment or additional treatments may be deemed necessary.
10. I understand that smoking and alcohol use can negatively affect healing. I agree to follow the recommended homecare instructions and agree to report for any recommended post-treatment examinations.
11. I consent to photography, filming, and x-rays taken before, during and after the procedure and understand this information may be utilized in education materials for the advancement of dentistry, provided such information is utilized in a manner compliant with current HIPAA regulations.

By signing below, I verify that I have read the above information completely and understand the language and words:

_____	_____	_____
Patient Signature (*sign prior to taking any medications*)	Date	In-Office Witness (PIC staff)

_____	_____	_____
Driver / Other person responsible for patient after treatment	Phone / Cell	Relationship to the Patient

I have explained the procedures, risks, consequences and alternatives relating to the surgery and/or procedure(s). The patient and/or the relative indicated appeared to understand and consent to the procedures prior to treatment.

_____	_____
Signature of the Doctor	Date

Cancellation Policy

Changed or cancelled surgical appointments require a minimum advance notice of 4 business days. A $75 dollar cancellation fee will be applied when any scheduled surgical appointment is cancelled or rescheduled without proper notice.

Prepayment, in part or full, may also be required to reserve a future treatment date if previous appointments have been cancelled without proper notice.

Please understand that appointment times in our clinic are reserved exclusively for you. We do not double-book our patients. Therefore, we ask for your courtesy to let us know when you are unable to keep a scheduled appointment so that your reserved time can be given to another patient.

I have read and understand the policy set forth above:

_____
Print Name

_____ _____
Sign Date

(405) 636-1411 ❖ 8203 S. Walker Oklahoma City, OK 73139 ❖ Fax (405) 636-1197
Email: okperio@yahoo.com ❖ Web: www.okperio.com