

## **WEST VALLEY PERIODONTICS**

### **Dental surgery consent form**

**Necessary Follow-up Care and Self-Care:** It is important for me to continue to see my regular dentist for routine dental care.

Smoking may adversely affect gum healing and may limit the successful outcome of my surgery. Studies show smokers have more gum problems than non-smokers and do not heal up as well.

I have told Dr. Bohra about any pertinent medical conditions I have, known allergies (especially to medications or sulfites (many local anesthetics have sulfite preservatives)), and medications I am taking, including over the counter medications such as aspirin, nutritional supplements and herbs.

I have told Dr. Bohra about any present or prior head and neck radiation therapy. I have told Dr. Bohra about any present or prior use of bisphosphonate medications. Some common brand names are Zometa®, Aredia®, Boniva®, Fosamax®, and Actonel®.

I may need to come back in for several post-op appointments following my surgery so that healing may be monitored and so Dr. Bohra can evaluate and report on the outcome of surgery to my dentist.

*Smoking, excessive alcohol intake or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery.* I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr. Bohra for post-operative check-ups as needed.
3. No smoking.
4. Perform excellent oral hygiene once instructed to, usually starting 1 week after the surgery is done.

**No Guarantee:** While in most cases dental surgery is successful, no guarantee has been given to me that the proposed dental surgery will be successful. Due to individual patient differences no one can predict certainty of success. There is a remote possibility of a worsening of my present condition, including the loss of teeth, despite the best of care.

**Publication of Records:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

**Communication with my insurance company, my dentist or other dental/medical providers:** I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during or after its completion with my insurance carriers, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Initials \_\_\_\_\_

**Females Only:** Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Procedure(s) performed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consent** I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling Dr. Bohra of any pertinent medical conditions and prescription and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Bohra. I have read and understand this document before I signed it.

\_\_\_\_\_  
Date [Printed name of patient, parent or guardian]

\_\_\_\_\_  
[Signature of patient, parent or guardian]

\_\_\_\_\_  
Date [Printed name of witness]

\_\_\_\_\_  
[Signature of witness]