Rice & Rollingson DENTISTRY

DR. ROBERT W. RICE
DR. TIM ROLLINGSON

Pre-Operative IV Sedation

1. Please do not eat solid foods for 6 hours prior to your appointment. If you need to take medication, please do continue to take your medication.
2. Please do not drink anything for 3 hours prior to your appointment.
3. Please wear a short sleeved shirt.
4. Plan ahead. If you are under 18 you must be accompanied by a responsible adult, who can sign for your sedation. Regardless of your age, you must have a ride home. You are considered impaired for 24 hours and cannot drive. You will also need someone to keep an eye on you following your appointment once you get home. Restart regular medications and take pain prescriptions as directed.

Following Your IV Sedation

1. Medications are in your system for 18 hours. Do not drive, operate machinery or make important decisions for 18-24 hours. Your memory will be compromised during this recovery time. This is normal and temporary. Drink lots of fluids but refrain from alcohol for 24 hours.
2. You can eat right away. A meal however, may re-sedate you. You may feel somewhat re-sedated in any case, a few hours later. This is normal. Rest at home in the accompaniment of a responsible adult. Restart regular medications and take pain prescriptions as directed. Do not take any other non-prescribed medications without prior consultation.
3. Your face and tongue may still be numb. Avoid burns by consuming moderately warmed food and beverages. Parents; observe your children carefully for signs of lip, tongue or cheek biting.
4. The IV site may be tender for a few days. Avoid heavy use of your IV arm for 48 hours. Contact our office if discomfort increases.
5. Do not drive or operate machinery for 24 hours.

Post-Op Instructions

Swelling, discomfort, stiffness and a small amount of bleeding following oral surgery is normal and expected. By following these instructions all of these can be kept to a minimum.

1. **DO NOT** smoke for at least 48 hours after surgery.
2. **DO NOT** use a straw for 48 hours after surgery.
3. **DO NOT** drink hot liquids or eat hot foods for 24 hours after surgery.
4. **DO NOT** rinse your mouth or brush your teeth until the day after surgery.
5. **DO NOT** touch the area where the work was done with your tongue or fingers.
6. For the first day or two, limit your diet to soft food, these may be warm or cold but not hot.
7. Starting the day after surgery, start brushing and rinsing your mouth. Be gentle but through; cleanliness is essential to proper healing. To rinse, we recommend ½ teaspoon of salt in one cup of warm water, four times daily.
8. Should bleeding occur, apply firm pressure with the cotton bandage you have been given for approximately 15 minutes and repeat as needed. Should bleeding be excessive or prolonged, call the office (403) 381-7423
9. Take your medications only as prescribed. Should the medication be inadequate, call our office.
10. Place ice packs to the area for 20 minutes and then remove for 20 minutes, repeat for 4-5 hours.
11. If you have been sedated, you MUST NOT operate a motor vehicle, hazardous devices or machinery, including household appliances, for 24 hours or more, until fully recovered from the effects of the anesthetic or drugs given for your care.
12. The use of alcohol, tobacco, and certain other drugs after sedation may be life endangering and must be avoided.

If you have any questions, consult with Dr. Rollingson, Dr. Rice or your family physician.

IN CASE OF EMERGENCY POST SURGERY CALL:

Dr. Robert W. Rice
335 Columbia Blvd W
Lethbridge, AB T1K 5Y8
(403)381-7423

Dr. Tim Rollingson
335 Columbia Blvd W
Lethbridge, AB T1K 5Y8
(403) 381-7423 (403) 393-3436 (cell)

Dr. Robert W. Rice B.Sc D.D.S
335 Columbia Blvd W
Lethbridge, AB T1K 5Y8
(403)381-7423

Dr. Tim Rollingson B.Sc D.D.S.
335 Columbia Blvd W
Lethbridge, AB T1K 5Y8
(403)381-7423

TREATMENT CONSENT FORM

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with the dental treatment, and the feasible treatment alternatives, and that you are given an opportunity to ask questions and those questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

My signature on the bottom of this form certifies that:

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.
2. I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.
3. I understand that the estimate given to me is for normal and usual treatment.
4. I understand that Dr. Rice/Dr. Rollingson has carefully examined my mouth. Alternatives to the chosen treatment have been explained. I have been informed and I understand the purpose and the nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of the prostheses.
5. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.
6. I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.

Patient/Guardian Initial X_____

7. I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.
8. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.
9. Dr. Rice/Dr.Rollingson has explained that there is no method to accurately predict the gum and the bone healing capabilities on each patient following tooth extraction or surgery.
10. I also understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of surgery. I agree to follow the home care instructions provided to me. I agree to report to Dr. Rice/Dr.Rollingson for regular examinations as indicated.
11. I agree to the type of anesthesia, depending on the choice of the doctor. If I have been sedated, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more after surgery, until fully recovered from the effects of the anesthetic or drugs given in my care.
12. I request and authorize medical/dental service for myself. I fully understand that during, and following the contemplated procedure or surgery, treatment conditions may become apparent which warrant, in judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, material, or care if it is felt this is for my best interest.

FOR ALL PATIENTS

I have been fully informed of the nature of dental treatment along with the possible risks and complications and hereby consent to treatment.

X

Date	**Print Name**	**Signature of Patient/Guardian**
Date	Print Name	Signature of Doctor
Date	Print Name	Signature of Witness

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

❑ YES ❑ NO ❑ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

❑ chest pain, angina	❑ rheumatic fever	❑ pacemaker	❑ steroid therapy	❑ seizures (epilepsy)	❑ osteoporosis medications (e.g. Fosamax, Actonel)
❑ heart attack	❑ mitral valve prolapse	❑ lung disease	❑ diabetes	❑ kidney disease	
❑ stroke		❑ tuberculosis	❑ stomach ulcers	❑ thyroid disease	
❑ shortness of breath	❑ heart murmur	❑ cancer	❑ arthritis	❑ drug/alcohol dependency	

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**