JONATHAN E MASON
DMD PC

JONATHAN E. MASON, DMD, PC
— General Dentist Providing Oral Surgery Services —

74 Longview Drive, Manchester Center, VT 05255
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PRE-OPERATIVE INSTRUCTIONS FOR DENTAL SURGERY

**** VERY IMPORTANT INFORMATION – PLEASE READ CAREFULLY ****

**** COMPLETE ATTACHED "MEDICAL HISTORY UPDATE FORM" ****
& RETURN IT TO YOUR DENTIST PRIOR TO SURGERY

1. If you have any concerns or questions about the surgery, please contact Dr. Mason at 802/362-1099 or by email at jmason@manchestervtdentist.com.
2. I will be reviewing your medical history with you immediately prior to the surgery. Please be sure you are familiar with that information – especially with the name(s) and dosage(s) of any medications you are taking. If you feel your history is relatively complicated, we will need to decide if a consultation with your physician is necessary before the procedure is performed.
3. Patients who are minors (under 18 years of age) must have a legal guardian present to both fill out the "Medical History Update Form" and to sign the "Disclosure and Consent Form."
4. It is important to avoid smoking for at least one week before the surgery and one week following the surgery.
5. Keep in mind that it is best to allow for some flexibility around your appointment time on the day of your surgery. It is best not to "squeeze in" an appointment for surgery on an already busy day.

If you are having I.V. (Intravenous) Conscious Sedation:

1. To reduce the chances of nausea, do not eat or drink anything (including water) for *at least six hours prior to your appointment*.
   - If your surgery is in the morning, do not eat or drink anything between bedtime and your scheduled appointment.
   - If your surgery is in the afternoon, a light breakfast before 7:00 a.m. is encouraged.
   - Unless specified by your dentist, all medicines taken on a routine basis should be continued without interruption. Please swallow with a minimal amount of water.
2. **A responsible adult, over 18 years of age, should accompany you to the office and should *remain in the office during the entire procedure*. Following the sedation, this responsible adult should be physically capable of assisting and accompanying you home and should remain with you for the next 24 hours.**
3. If receiving intravenous sedation, you should wear clothing, which is not restricting to the neck or arms. You should wear loose-fitting tops on which the sleeves can be rolled up to the shoulder. Also, please be sure to wear shoes that are securely fastened; no flip-flops or loose-fitting sandals, please.
4. Following the sedation, you should refrain from driving an automobile or engaging in any activity that requires alertness for the next 24 hours.
5. There are important differences between general anesthesia (being completely asleep) and I.V. Conscious Sedation. If you have any questions about the I.V. Conscious Sedation process, please feel free to contact Dr. Mason at 802/362-1099 prior to the procedure.

NOTE: Additional pre-operative information can be found at *www.manchestervtdentist.com.*
I recommend you preview the "Disclosure and Consent Form" on the Website,
or you can request a copy from your dentist

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MEDICAL HISTORY UPDATE FORM

Date_____

Name_____ Dentist's Name:_____
Last First Middle

Social Security #_____ Ht_____ Wt_____ Date of Birth_____

If you are completing this form for another person, what is your relationship to that person?_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

1. Are you in good health?..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition?_____
5. The name and address of your physician is:

   _____

   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
7. Are you taking any medicine(s), including non-prescription medicine(s)? ..... Yes No
   If so, what medicine(s) are you taking?_____

   _____
8. Have you ever taken Aredia, Zometa, Fosamax, Actonel, or Boniva? ..... Yes No
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease ..... Yes No
   b. Cardiovascular disease, angina, heart attack, heart trouble, stroke ..... Yes No
   c. Osteoporosis..... Yes No
   d. Cancer requiring I.V. chemotherapy ..... Yes No
   e. Asthma or hay fever ..... Yes No
   f. Fainting spells or seizures ..... Yes No
   g. Diabetes..... Yes No
   h. Hepatitis, jaundice, or liver disease..... Yes No
   i. AIDS or HIV infection..... Yes No
   j. Thyroid problems..... Yes No
   k. Respiratory problems, bronchitis, etc. Yes No
   l. Stomach ulcer or hyperacidity ..... Yes No
   m. Kidney trouble ..... Yes No
   n. High or Low blood pressure..... Yes No
   o. Sexually transmitted disease ..... Yes No
   p. Epilepsy/other neurological disease? ..... Yes No
   q. Problems with the spleen ..... Yes No
10. Have you had abnormal bleeding? ..... Yes No
    Or required a blood transfusion? ..... Yes No
11. Do you have any blood disorder such as anemia? ..... Yes No
12. Have you been treated for a tumor? ..... Yes No
13. Are you allergic or have you had a reaction to:
    a. Local anesthetics..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives, sleeping pills .... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Other_____

Women

14. Are you pregnant? ..... Yes No
15. Do you have any menstrual problems? ..... Yes No
16. Are you nursing? ..... Yes No
17. Are you taking birth control pills?..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history.

_____ _____
Signature of Dr. Mason Signature of Patient (or Patient's Guardian)

**** RETURN THIS COMPLETED FORM TO YOUR DENTIST PRIOR TO SURGERY ****

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DISCLOSURE AND CONSENT – DENTAL AND ORAL SURGERY

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request Jonathan E. Mason, DMD, PC and such associates, technical assistants, and other healthcare providers as they may deem necessary, to treat my condition which has been explained to me as:

Non-restorable, Periodontally-involved, and/or Impacted Teeth_____

I(we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me(us), and I(we) voluntarily consent and authorize these procedures under local anesthesia supplemental by: ____ Nitrous Oxide ____ I.V. Sedation ____ Oral Sedation

Surgical Extraction of Teeth_____

I(we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize my doctor and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written post-operative instructions, and I(we) agree to personally contact Dr. Mason in the event I(we) have a problem. I(we) will follow his instructions until that problem has been satisfactorily resolved. I(we) realize that in the event I(we) develop certain complications, I(we) may miss school or work schedules or I(we) may incur additional, unexpected expenses, including, but not limited to, expenses for other dentists, doctors, or medical facilities.

I(we) have chosen Dr. Mason from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Mason is a General Dentist.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I(we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions, and even death. I(we) also realize that the following risks and hazards may occur in connection with this particular procedure:

_____ 1. Temporary or permanent nerve injury resulting in altered sensations or numbness of the lips, chin, tongue, teeth, and/or gums.

_____ 2. Damage to adjacent teeth and/or dental restorations.

_____ 3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, face, and/or jaws.

_____ 4. Opening of the sinus requiring additional treatment.

_____ 5. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks.

_____ 6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications.

_____ 7. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent.

_____ 8. Other_____

I(we) understand that I.V. Conscious Sedation ("twilight sleep") and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of I.V. Conscious Sedation and/or other forms of supplemental anesthesia to assist in the relief and protection from pain during the planned and additional procedures. I(we) realize the I.V. Conscious Sedation and/or other forms of supplemental anesthesia may have to be changed possibly without explanation to me(us). I(we) understand this is not general anesthesia (being completely asleep), and that it is unlikely, but I may have unpleasant memories of the procedure.

I(we) understand that certain complications may result from the use of any I.V. sedative or other form of anesthesia, including respiratory problems, drug reactions, paralysis, brain damage, or even death. Other risks and hazards which may result from the use of I.V. sedation or other sedatives or anesthetics range from minor discomfort to injury of the vocal chords, teeth, and/or eyes.

I(we) have been given an opportunity to ask questions about my(our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify this form has been fully explained to me(us), that I(we) have read it or have had it read to me(us), that the blank spaces have been filled in, and that I(we) understand its contents

DATE:_____ TIME:_____

_____	/_____
Signature of Patient or Other Legally-responsible Person	/ Patient's Name (Please Print)

WITNESS:_____ DATE:_____

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Informed Consent for Endodontic Treatment

_____ This is my consent for Jonathan E. Mason, DMD, PC to perform the following treatment_____

_____

as previously explained to me, or other procedures deemed necessary or advisable to complete the planned procedure.

_____ I understand that the purpose of the procedure is to retain a tooth that may otherwise require extraction, to correct a failed root canal, or other problems:_____. Although endodontics has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had endodontics may require re-treatment, surgery, or even extraction.

_____ Dr. Mason has explained to me that there are certain inherent and potential risks in my treatment plan or procedure, and that in this specific instance, such risks include, but are not limited to:

1. Post-operative discomfort and swelling and possible post-treatment infections.
2. Trismus (restricted jaw opening) and/or injury to the temporomandibular joint because of injections, infections, and holding jaw open for prolonged periods./
3. Instrument breakage within canals, perforations (extra openings) while locating canals, and some canals may not be located.
4. Damage to existing fillings, crowns, porcelain veneers, or bridges.
5. Loss of tooth structure in gaining access to canals and possible injury to adjacent teeth and fractured teeth.

_____ Following treatment, the tooth may be brittle and subject to fracture. A restoration, crown, and/or post and core would then be necessary to restore the tooth to function. I understand I may be required to return to my dentist for this restoration.

_____ I consent to the administration of such local anesthesia as deemed necessary by Dr. Mason to accomplish the proposed procedure. Risks of local anesthesia include, but are not limited to: numbness or the tingling of the lip, chin, gums, cheek, teeth, and/or tongue.

_____ Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle, automobile, or hazardous devices or to work while taking such medications and/or drugs, until fully recovered from their effects.

_____ If any unforeseen condition should arise in the course of treatment, calling for Dr. Mason's judgment or for procedures in addition to or different from those now contemplated, I request and authorize Dr. Mason to do whatever he may deem advisable.

_____ I understand that other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include, but are not limited to: pain, infection, swelling, loss of teeth, and infection to other areas.

_____ No assurance or guarantee has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided.

_____ I have had an opportunity to discuss with Dr. Mason my past medical and health history, including any serious problems and/or injuries. I understand that Dr. Mason is a general dentist who provides endodontic services.

I certify that I have had an opportunity to read and fully understand the terms and words within this consent form. All blanks or statements requiring insertion or completion were filled in, and inapplicable paragraphs, if any, were stricken before I signed. I also certify that I have had the opportunity to fully discuss the procedure(s) with Dr. Mason. I have had the opportunity to ask any questions, and I have had all of my questions answered.

_____ _____
Date **Time**

_____ _____
Signature of Patient (or other legally responsible person) **Patient Name (PLEASE PRINT)**

_____ _____ _____ _____
Signature of Dr. Mason **Date** **Signature of Witness** **Date**

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POST-OPERATIVE INSTRUCTIONS FOLLOWING DENTAL SURGERY

THINGS TO EXPECT:

Bleeding: Bleeding or "oozing" for the first 12 to 24 hours.

Swelling: This is normal following a surgical procedure in the mouth. It should reach its maximum in two-to-three days and should begin to diminish by the fifth post-operative day.

Discomfort: The most discomfort that you may experience may occur for a few hours after the sensation returns to your mouth. It may gradually increase again for 2-3 days, then begin to diminish over the next few days.

THINGS TO DO IMMEDIATELY FOLLOWING SURGERY:

Bleeding: Place gauze over extraction sites and maintain pressure by biting for at least one hour. Repeat as needed. Keep head elevated, and rest. Do not suck or spit excessively. (Also, please refrain from blowing into musical instruments.)
NOTE: Some "oozing" and discoloration of saliva is normal. If bleeding persists, replace the gauze with a clean, folded gauze placed over the extraction site, and maintain the pressure until the bleeding stops.

Swelling: Place ice or cold compresses on the region of surgery for ten minutes every half-hour for the first 8-12 hours.
NOTE: Ice bags or cold compresses should be used only on the day of surgery.

Smoking: Avoid smoking during the healing period.

Discomfort: Take medications as directed for PAIN. Mild-to-moderate pain can be relieved by non-prescription Advil, Aleve, or Orudis. For more severe pain, take the prescription pain medication as directed. Remember that these medications can take up to 30 minutes to one hour to take effect. If you are using any of these medications for the first time, exercise caution with the initial doses (start with ½ a pill).

Diet: A nutritious liquid or soft diet will be necessary for the first weeks after surgery. Healing will occur in weekly increments; therefore, it is best to gradually (in weekly increments) return the diet and/or other mouth/oral activities back to normal.

Physical Activity: For the first 24 to 48 hours, one should REST. Patients who have sedation should refrain from driving an automobile or from engaging in any task that requires alertness for the next 24 hours.

THE DAYS AFTER SURGERY:

1. Brush teeth carefully.
2. Beginning 24 hours after the surgery, rinse mouth with *WARM SALT WATER* (or prescription mouth rinse). Continue rinsing three-to-five times per day for seven days, then begin irrigating per dentist's instructions (see #7 below).
3. If *ANTIBIOTICS* are prescribed, be *SURE* to take *ALL* that have been prescribed, *AS DIRECTED*.
4. Use *WARM, MOIST HEAT* on face for swelling, if any. Continue until the swelling subsides. A warm, wet washcloth or heating pad will suffice.
5. If *SUTURES* were used, they will dissolve on their own.
6. *DRY SOCKET* is a delayed healing response, which may occur during the second to fourth post-operative day. It is associated with a throbbing pain on the side of the face, which may seem to be directed up toward the ear. In mild cases, simply increasing the pain medication can control the symptoms. If this is unsuccessful, please call Dr. Mason.
7. **RETURN TO YOUR DENTIST'S OFFICE** five-to-seven days after the surgery for irrigation instructions.
8. Additional post-operative information can be found at *www.manchestervtdentist.com***.**

CONTACT THE DOCTOR IF:

1. Bleeding is excessive and cannot be controlled.
2. Discomfort is poorly controlled.
3. Swelling is excessive, spreading, or continuing to enlarge after 60 hours.
4. Allergic reactions to medications occur, which are causing a generalized rash or excessive itching.

CONTACT EMERGENCY MEDICAL SERVICES ("EMS") OR CALL "911" IF:

Patient loses or has lost consciousness.

***** BE SURE TO CHECK THE WEB SITE FOR ADDITIONAL INFORMATION *****
— www.manchestervtdentist.com —