K. Scott Williams DDS•PA

K. SCOTT WILLIAMS, D.D.S., P.A.
— General Dentist Providing Oral Surgery Services —

_____ (ofc) 972.743.6561 (cell) scott@kswdds.com www.kswdds.com

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. Williams at 972/743-6561 or by email at scott@kswdds.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. Williams at 972/743-6561 prior to the procedure.

NOTE: Additional pre-operative information can be found at *www.kswdds.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

Name _____ Date _____
Last First Middle

Height _____ Weight _____ Date of Birth ____/____/____ Dentist's Name _____

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
   Is patient developmentally delayed or mentally challenged? ..... Yes No
   Is patient being treated for ADD, ADHD, or any other mental health disorder? ..... Yes No
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. Sleep apnea or snoring during sleep ..... Yes No
   m. Stomach ulcer or hyperacidity ..... Yes No
   n. Kidney trouble ..... Yes No
   o. High or Low blood pressure ..... Yes No
   p. Sexually transmitted disease ..... Yes No
   q. Epilepsy/other neurological disease? ..... Yes No
   r. 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. Williams

_____
Signature of Patient (or Patient's Guardian)

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

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PATIENT TREATMENT RECORD — FOR DENTIST'S USE ONLY

Name_____ **Age**_____ **DOB**___/___/_____ **Date**___/___/_____

Address_____ **City/ST**_____ **Zip**_____

Email:_____ **Phone:**_____

Diagnostic Criteria: **Perio**_____ **Crowding**_____ **Pt. Election**_____

Prev. Pain/Swelling _____ **N/R Caries**_____ **Cyst**_____ **Other**_____

M.H.R. Pertinent Findings:_____

_____

_____ ***Allergies:***_____

☐ ***Consent Signed*** ***N.P.O. x*** _____ ***hrs.*** ***ASA*** _____ ***BMI***_____

Dentist's Office:_____ **Fee:**_____

Procedure Planned:_____ **S/F:**_____

Pre-Operative X-ray: ☐ **Pano** ☐ ***PA*** ***Other***_____ ***Date*** ___/___/_____ **I/F:**_____

Pre-Op Meds/Drugs_____ **O/F:**_____

Post-Op Ride_____ **Post-Op Ride's #**_____

Pre-Op Vital Signs: *ECG*_____ *PSO2*_____ *RR*_____ *BP*_____ *HR*_____

Sutures: *Silk; Gut; Vicryl;*_____ **Assts:**_____ **Asst. Fee:**_____

Rx:

☐ Ibuprofen 600mg x 20; Take 1 tab q6h for 3 days prn pain, then take 1 q6h prn
☐ Penn VK 500mg x 20; Take 1 tab q6h until gone
☐ Peridex (1 pint) x 1; Swish ½ oz. morning and night, until gone
☐ Zofran ODT 8mg x 10; Take 1 q8h prn nausea
☐ Azithromycin 250mg x 5; Take 2 tabs day 1, then 1 tab daily on days 2-4
☐ Ultram 50mg x 20; Take 1-2 q4-6h prn pain
☐ Other:_____

For nitrous oxide patients:

☐ N20 (L/Min)—6L/Min @ 50% Start____:____ End____:____

☐ Oxygen (L/Min)—3L/Min @ 100% 5 min. post-op

2% Lidocaine Carps. 1:100k _____

0.5% Marcaine Carps. 1:200k _____

Procedure Completed/Clinical Notes Transalveolar removal of teeth #s:

_____

EBL< cc. Patient tolerated procedure

_____

_____

_____

For Office Use Only:
Post-Op Call _____
Comment Card _____
Posted _____
Drug Log _____
1-wk. Post-Op Call

☐ **Post-op instructions given (W&O)** ☐ **D/C Criteria Met Per Rule 110.5(6) C&D**

SEDATION RECORD

Date Name							Pre-op vitals		BP		HR		SpO_2	RR
							Age	Gender M F	Weight Lbs		Height	BMI	Mallampati	ASA
Medical History Medications							NPO Status Solids Hours Clear liquids Hours Procedure(s)						NIBP L R Pulse oximeter Precord ECG EtCO2	
							Operator				Assistant			
Drug Allergies Escort ☐								Start	Finish	Premed	IV 20G 22G 24G R L Site			
							ANES							
							SURG							

TIME														
Oxygen (L/min)														
Nitrous Oxide (L/min)														
													Used	Wasted
Midazolam (mg)														
Fentanyl (mcg)														
Meperidine(mg)														
Dexmedetomidine (mcg)														
Ondansetron (mg)														
Ketorolac (mg)														
Dexamethasone (mg)														
.9% NaCl/.5% Dextrose .45% NaCL														
Lactated Ringer's														
2% lidocaine 1:100K epi (mg)														
.5% Bupivicaine 1:200K epi (mg)														
SpO_2														
Respiratory Rate														
$EtCO_2$														
ECG														

Discharge to

BP 150

HR

SpO2

50

RR

Comments

Operator Signature: _____

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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 K. Scott Williams, D.D.S., P.A. and such associates, technical assistants, and other health care 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 (D7210)_____

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. Williams 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) understand Dr. Williams is not employed by my dentist but is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Williams from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Williams 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. **Please read and initial #1-7 below**.

_____ 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.

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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POST-OPERATIVE INSTRUCTIONS

- In your post-op bag that we are sending home with you, you have written instructions, extra gauze (which I will show you how to change in a moment), and your prescriptions form. On the outside of the bag there is a sticker with pertinent information, along with Dr. Williams's contact number and his website that has helpful videos, how to's, and post-op instructions as well.

- Your prescriptions are for an ANTIBIOTIC (Penicillin or Azithromycin/Z-Pak, typically), which you will want to start at the time indicated on the outside of your post-op bag. Make sure you take ALL of this prescription (there is one refill on the antibiotic, if needed). You have been given two medicines already, either through the IV or by injection. One is a steroid to reduce inflammation, and one is an NSAID, which is an anti-inflammatory—both of which will reduce the potential of swelling. Because you have been given these medications already, you will not need to take any medicines for pain for six hours (the time will be written on the sticker on the outside of your post-op bag). At the time indicated, you will begin taking your prescription IBUPROFEN 600mg AND TYLENOL EXTRA STRENGTH 500mg TOGETHER. Do not alternate these medications. Tylenol Extra Strength is an over-the-counter medication, and it comes in 500mg tablets, so you will need to take one. You will repeat this dosage combo every eight hours for three days. After three days, take as needed/if needed. This dosage regimen is typically all you will need to take care of your discomfort. You have also been given a prescription for ZOFRAN in the event of nausea. There is also a prescription for a medicated mouth rinse (PERIDEX) which you will not start using until tomorrow, 24 hours after surgery. Use this rinse AFTER you have eaten and brushed your teeth in the morning and the last thing before bed every night for at least one week. In addition to PERIDEX, rinse with warm salt water beginning the day after surgery every time you have a meal or snack. It is also a good idea to rinse after you drink anything other than water. On the two days after your surgery day, you will just gently rinse (no vigorous rinsing/swishing/spitting) by rocking your head back and forth and letting it fall out of your mouth while leaning over the sink. Beginning on the third day after your surgery day, rinse vigorously every time you eat or drink. Continue vigorous rinsing until sockets heal.

- Discomfort is directly related to swelling. If we can keep you from swelling, or limit the amount of swelling that you have, we can keep you comfortable. Once you get home, you will want to use ice packs by placing on the outside of both cheeks 20 minutes on/off throughout the day as much as possible. (Ice in Ziplock baggies, with a thin cloth wrapped around it, works great if you do not have ice packs.) If you do not ice today, you have the increased potential for swelling. Ice is not indicated after 24 hours.

- Change out your gauze in one hour, and then repeat the process once every hour until you remove the gauze and it is just pink. At that point, you have pretty much stopped bleeding and can leave the gauze out. You want to keep direct pressure on the gauze by firmly biting down; the harder you bite, the faster you will stop bleeding. If you continuously change the gauze and it is red and saturated, this is an indication that you are not biting hard enough on the gauze and/or the gauze is not properly placed over the sockets. When it is time to change the gauze, that is the ideal time to eat/drink, then replace the gauze, if necessary. DO NOT SLEEP WITH GAUZE IN YOUR MOUTH as doing so would present a choking hazard.

- For the next three days, you will want to avoid any carbonated beverages (soda, beer, champagne). You will also want to avoid anything that creates a suction in the mouth (no drinking through a straw, sucking on water/sports bottles or juice boxes, no chewing gum/mints/suckers, and no smoking or vaping).

- NO rinsing your mouth or brushing your teeth for the first 24 hours. After that, you should resume brushing your teeth. Brush your teeth as you normally would, including your back teeth. Tenderness and slight bleeding are to be expected. The cleaner you keep your mouth, the faster you will heal. Any food debris, plaque, or bacteria in the mouth delays healing and increases the potential for swelling, infection, or dry socket. After you brush your teeth, you can put water in your mouth, rinse by shaking your head from side-to-side, and lean head over the sink, letting water fall out into the sink. No vigorous rinsing/swishing/spitting for the first two days after your surgery day. Beginning on the third day after your surgery day, you can start a vigorous rinse with regular water, warm salt water, or medicated mouth rinse after every meal or snack to make sure that sockets stay clean.

- Depending on your metabolism, you could be numb anywhere from 8-24 hours.

- As far as your diet, stay with just liquids the remainder of today (broth, yogurt, pudding, milkshakes thick enough to eat with a spoon, protein drinks, and ice cream). It is important to keep up your calorie intake, as your body needs the calories to heal. Also, it is important to stay hydrated. Starting tomorrow, eat a soft diet, such as yogurt, pasta, baked/mashed potatoes, scrambled eggs, oatmeal, and flaky fish. Do not eat anything hard, crunchy, or chewy. Gradually start adding more solid foods into your diet after a week or so.

- As far as returning to school, you will miss the remainder of today and probably tomorrow (play it by ear). You will want to refrain from sports activities or marching band for 3 days. If you play a wind instrument, please refrain from doing so for 1-2 weeks.

- Regarding physical activity, you should rest for the first 24-48 hours. Patients who have had sedation should refrain from driving an automobile or from engaging in any task that requires alertness for the next 24 hours.

****If you have any questions or concerns,****
please call or text Dr. Williams at 972.743.6561.

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of K. Scott Williams, D.D.S., P.A.'s Notice of Privacy Practices effective 3/1/17.

Patient's Name (please print)_____

_____ _____
Signature of Patient Date Signed

****

I am a parent or legal guardian of _____ (patient's name). I have received a copy of K. Scott Williams, D.D.S., P.A.'s Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian's Name (please print)_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

_____ _____
Signature of Parent or Legal Guardian Date Signed

I authorize the doctor and his staff to contact me by ____ phone ____ email ____ mail *(check all that apply)*

****

If the patient or the patient's parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on _____ (date)

☐ In Person ☐ Email ☐ Mail ☐ Other_____

Reason patient or patient's parent/legal guardian did not sign this form:

☐ Did not want to sign
☐ Did not respond after more than one attempt
☐ Other_____

_____ _____
Staff Member's Name (please print) Title

_____ _____
Signature of Staff Member Date Signed