At Tooth Docs, we strive to provide dental experiences for our patients that are nothing short of positive and comfortable. One way we do this is by prescribing anti-anxiety medication. **Due to an altered state of consciousness, you must have a reliable driver who can bring you to and from your appointment and oftentimes depending on your level of consciousness, this person may need to stay with you for the rest of the day**.

PATIENT NAME: **STAFF NAME:**

DRUGS ALLERGIES
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions, including heart irregularities. **I have informed the doctor of any known allergies**.

CURRENT MEDICATIONS/CONDITIONS:

KNOWN DRUG ALLERGIES:

If you have any questions about your proposed treatment, please ask your doctor BEFORE initialing or signing this form. Anxiolytics are intended to make your dental treatment a comfortable experience. They are suitable for most people, but if you are not in good health or if you are taking medication, you need to let us know, so the medication can be modified to suit your needs. By initialing, you are indicating that you understand & have been informed of our protocols. These protocols are so important that failure to observe them could potentially result in cancellation of your treatment that day. ***WOMEN: If you are pregnant, you are NOT a candidate for sedation medications.***

X _____ ***PRE-OP TREATMENT***

- ☑ After your appointment is scheduled, **your prescription will be sent to a pharmacy and you will have to pick it up.**
- ☑ Your medication will cause drowsiness.
- ☑ We recommend scheduling an **early appointment** with a **light breakfast** giving you the remainder of the day to rest.
- ☐ In some cases, we will have given you **antibiotics prior to surgery**. Some patients experience gastrointestinal difficulties with antibiotics and it is helpful to start taking Probiotics (you can get these at any pharmacy) when you start taking the antibiotics. Probiotics help replenish the good bacteria in your intestines that antibiotics can kill off.
- ☐ Are you on a daily aspirin or are on **blood thinners**?

X _____ ***DESIGNATED DRIVER***

- ☑ You **MUST be accompanied by someone to drive you to and from surgery**, and stay with you for several hours until you have recovered sufficiently to care for yourself.

- [x] During recovery time (normally 24 hours), **you should not drive, operate complicated machinery or devices or make important decisions**, including watching children and cooking. **ABSOLUTELY NO RECREATIONAL DRUGS OR ALCOHOL** 24 hours before or after treatment.

X _____ ***POST OP TREATMENT***

- [ ] I have received a post op oral surgery instruction form
- [ ] I have received a post op implant instruction form
- [ ] I have received a post op root canal instruction form
- [ ] I have received a temporary crown instruction form
- [ ] I have received a post op denture instruction form
- [ ] Sometimes we give you **pain medicine** prior to your surgery date. Make sure you wait until after the effects of your anti-anxiety medications have worn off prior to taking any narcotics unless instructed otherwise by the doctor.
- [x] If you are able to take Ibuprofen (ie: Advil), take 600 mg every 6 hours as needed. Do not take Tylenol with your prescribed pain medication if it already contains Tylenol/acetaminophen.

DRIVER OR EMERGENCY NAME: _____ **PHONE NUMBER:** _____
DRIVER MUST STAY WITHIN A 5-10 MINUTE RADIUS OF THE OFFICE IN CASE OF AN EMERGENCY OR TREATMENT IS FINISHED BEFORE ESTIMATED TIME.

I understand I am having the following dental treatment performed:

- [ ] SEALANT(S)
- [ ] FILLING(S)
- [ ] ROOT CANAL(S)*consent*
- [ ] IMPLANT(S) *consent*
- [ ] CROWN(S)/BRIDGE(S)
- [ ] BONE GRAFT(S)
- [ ] EXTRACTION(S)/ALVEOPLASTY *consent*
- [ ] CROWN LENGTHENING
- [ ] OTHER: _____

Changes in Treatment Plan: I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my financial responsibility, but will be communicated with me only during times in which I have sound mind or will be communicated with my designated authorized representative.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

Patient's (or Legal Guardian's) Signature _____ Date _____

Witness' Signature _____ Date _____