Clyde Robinson, D.D.S, M.Sc.D & Clark Mackelprang, D.D.S., M.S.

Tucson Dental Implants & Periodontics

Consent for Anesthesia

I, hereby give my consent for Dr. Clyde M. Robinson and/or Dr. Clark Mackelprang and/or any such assistants as may be selected and supervised by the doctor to administer to me the following anesthesia.

Local Anesthesia: Lidocaine, Carbocaine/Mepivacaine, Marcaine, Septocaine

Analgesia: Inhalation of Nitrous Oxide

Oral Sedation: Halcion

Intraveneous and/or Intramuscular Conscious Sedation: Versed, Demerol, Phenergan

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The purpose of the anesthesia and the details regarding the administration of the anesthesia has been explained to me and I understand them.

The risks, benefits and possible complications regarding the administration and use of anesthesia have been explained to me and I understand them.

If oral, intravenous or intramuscular sedation are administered, I agree not to drive an automobile or operate heavy equipment for 24 hours after the procedure. I will arrange for transport for myself after the procedure and for someone to care for me until I am able to care for myself.

I have been given the opportunity to ask questions and express concerns I have about the anesthesia. The undersigned provider has answered my questions and addressed my concerns.

_____ _____

Patient/Legal Guardian Signature Date

_____

Witness

www.gumsandimplants.com
2330 North Rosemont Tucson, AZ 85712
Phone: 520.327.0263 ◦ Fax: 520.327.0965

Clyde Robinson, D.D.S, M.Sc.D & Clark Mackelprang, D.D.S., M.S.

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Consent for Periodontal Surgery

The nature, purpose and procedures of the proposed periodontal surgery have been explained to me and I understand them. I understand that local anesthetic will be used to control pain. I have been advised of the advantages and disadvantages of possible alternative treatments and my prognosis if no treatment is received.

I understand that the success of the periodontal surgery cannot be determined in advance and I acknowledge that no guarantees have been made to me regarding the results of this surgery. The risks, benefits and possible complication of the proposed surgery, including the risk that such surgery may not accomplish the desired objective have been fully explained to me. Should complications occur during or after the procedures, I understand that additional procedures may be necessary including corrective surgery. This may result in additional charges that cannot be foreseen.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

Following the completion of periodontal therapy I understand that it is my responsibility to maintain my teeth and gums in a state of health with adequate daily oral hygiene and periodic cleanings.

I certify that I have read and fully understand the above informed consent and hereby authorize the undersigned provider to perform periodontal surgery.

_____ _____

Patient/Legal Guardian Signature Date

_____

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Consent for Treatment

I, the undersigned patient, hereby authorize the undersigned provider or his assistants, as may be selected by him, to perform the procedure(s) or course(s) of treatment listed below.

_____ Occlusal Adjustment

_____ Occlusal Orthotic Appliances

_____ Periodontal Maintenance

_____ Disease Control Therapy
(Scaling/Root Planning, Curettage, Localized Antibiotic Placement)

_____ _____

I understand my dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I confirm that I understand this form and the information contained therein.

_____ _____

Patient/Legal Guardian Signature Date

_____

Witness

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Implant Consent

I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or the bone.

Alternatives to this treatment have been explained. I understand that if nothing is done, any of the following could occur: migration of existing teeth resulting in malalignment, bone disease, loss of bone, gum tissue inflammation, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

I have been informed that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant. It has been explained that in some instances implants fail and must be removed. 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 results of treatment or surgery can be made.

I have further been informed of the possible risks and complications involved with surgery, drugs, and sedation. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reaction to materials used during the implant procedure.

I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I request and authorize dental services including implants and other procedures necessary for the placement of those implants. I fully understand that during and following the implant procedure, surgery conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of implant treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

_____ _____

Patient/Legal Guardian Signature Date

_____

Witness

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Site Preparation Consent

(Extraction, Bone grafting, Barrier membrane Surgery)

I have been informed and I understand the purpose and nature of the site preparation surgery procedure. I understand what is necessary to accomplish extraction of the tooth/teeth, placement of bone graft material, and barrier (tissue blocking) membrane.

Alternatives to this treatment have been explained. I understand that if nothing is done, any of the following could occur: migration of existing teeth resulting in malalignment, bone disease, loss of jaw bone, gum tissue infections, loss of adjacent teeth, abscess formation and/or progression.

I have been informed that there is no method to accurately predict the gum and the bone healing capabilities in each patient following site preparation surgery. It has been explained that in some instances bone grafts fail and may have to be redone. 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 results of treatment or surgery can be made.

I have further been informed of the possible risks and complications involved with surgery, drugs, and sedation. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are injury to adjacent teeth present, bone fractures, sinus penetration, delayed healing, allergic reaction to materials used during site preparation surgery.

I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the surgery. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dusts, blood or bloody diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I request and authorize dental services including other procedures necessary for the completion of the surgery (i.e. removal of crowns/caps, bridges, or fillings). I fully understand that during and following the site preparation surgery, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of treatment. I also approve any modification in design, materials, or care, if it is felt this is in my best interest.

_____ _____

Patient/Legal Guardian Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

(You May Refuse to Sign This Acknowledgement)

I, _____, have received a copy of this offices Notice of Privacy Practices.

_____ _____

Print Name Date

_____

Signature

As part of my healthcare, I understand that oral communication is important and that if I do not specify individuals to whom my information may be released to, Dr. Clyde M. Robinson and Staff will not disclose this information under any circumstances without a written authorization.

In my absence, Dr. Clyde M. Robinson and Staff may discuss my medical condition with the following individuals:

_____ _____

Name & Relationship to Patient Name & Relationship to Patient

_____ _____

Name & Relationship to Patient Name & Relationship to Patient

☐ I agree that Dr. Clyde Robinson and Staff may leave detailed messages regarding my medical condition at the following phone number(s):

_____

☐ I do not wish to have messages left with individuals or answering machines.

☐ I have additional restrictions for the use or disclosure of my health information:

_____

_____

☐ No restrictions are in place at the time of signing this consent

_____ _____

Patient's Name (Print) Patient's Signature

Clyde Robinson, D.D.S, M.Sc.D & Clark Mackelprang, D.D.S., M.S.

Tucson Dental Implants & Periodontics

Consent for Oral Surgical Treatment with Bisphosphonate Drugs

Patient's Name: _____ Date: _____

Please initial each paragraph after reading.

If you have any questions, please ask your doctor BEFORE initializing.

IMPORTANT: Having been treated previously with Bisphosphonate drugs, you should know that there is a significant risk of future complications associated with dental treatment. Bisphosphonate drugs appear to adversely affect the ability of bone to break down or remodel itself thereby reducing or eliminating its ordinary excellent healing capacity. This risk is increased after surgery, especially from extraction; implant placement or other "invasive" procedures that might cause even mild trauma to bone. Osteonecrosis may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult or impossible to eliminate.

Your medical/dental history is very important. We must know the medications and drugs that you have received or taken or are currently receiving or taking. An accurate medical history, including names of physicians is important.

_____ 1. Antibiotic therapy may be used to help control possible post-operative infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc.

_____ 2. Despite all precautions, there may be delayed healing, osteonecrosis, loss of bony and soft tissues, pathologic fracture of the jaw, oral-cutaneous fistula, or other significant complications.

_____ 3. If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, long-term antibiotics, and debridement to remove non-vital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws, and/or skin flaps and grafts.

_____ 4. Even if there are no immediate complications from the proposed dental treatment, the area is always subject to spontaneous breakdown and infection. Even minimal trauma from a toothbrush, chewing hard food, or denture sores may trigger a complication.

_____ 5. Long-term post-operative monitoring may be required and cooperation in keeping scheduled appointments is important. Regular and frequent dental

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check-ups with your general dentist are important to monitor and attempt to prevent breakdown in your oral health.

_____ 6. I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to do so may adversely affect my care and lead to unwanted complications.

_____ 7. I realize that despite all precautions that may be taken to avoid complications; there can be no guarantee as to the result of the proposed treatment.

CONSENT

I certify that I speak, read, and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

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

_____ _____
Doctor's Signature Date

_____ _____
Witness Signature Date