

Extractions—Post Operative Instructions

1. When you leave the office, you will be biting on some gauze. Please continue to bite with firm pressure for 15-20 minutes. At this time, remove the gauze and place another packing in the extraction site. Make sure to wet the gauze and fold into a pillow and bite down with firm pressure. The majority of the bleeding should stop within 20-30 minutes of leaving the office. If heavy bleeding continues, call us at Valley View Dental immediately.
2. If a prescription medication was given after your procedure, take as directed before the anesthetic wears off. This is a more effective way of using the medication than to wait until discomfort has started.
3. Avoid smoking, alcohol, and carbonated beverages for at least 24 hours. Spitting or sucking through a straw should also be avoided to prevent the dislodging of the clot. This can cause a dry socket which is very painful. Please eat soft foods the day of the surgery and avoid foods such as peanuts, popcorn, or rice for a couple of weeks until the extraction site has healed over.
4. Do not brush your teeth the day of the surgery. After 24 hours, you can brush and floss like normal (carefully around the extraction site) followed by rinsing gently with a warm salt water rinse (1 teaspoon salt to 6-8 oz of water). This will cleanse the extraction site. Continue to do so 3-4 times per day for approximately 1 week.
5. If a temporary denture was inserted that day, please return the following day for an adjustment.

Consent for Extractions: Valley View Dental Inc.

I, _____ give my consent for Dr Miller and agent and
Patient or Parent /Guardian (if the pat is under 18 or mentally handicapped)
employees or assistants authorized by them, to perform the following procedure on:

Patients Name

Procedure:

I am aware that this procedure is being recommended to treat disease of my (or the patient's) mouth and jaw. I understand that there are alternatives to this treatment, including No Treatment.

I understand that there are potential side effects, risks or complications that may occur with this procedure, and I am willing to accept these risks in order to have (or for the patient to have) the proposed surgical procedure. These side effects and risks may include, but are not limited to:

1. Swelling, pain, bruising, lip cracking, restricted mouth opening, nausea, and/or diet changes that may require several days of home recovery.
2. Bleeding and/or infection, which may require returning to the office (or, in some cases, the hospital) for treatment.
3. If an **Upper** tooth is to be removed, or lower jaw or soft tissue surgery is to be performed, an opening from the mouth may occur into one of the sinus cavities or the nose. Additional surgery may be necessary to close this opening, which would be done at the specialist (Oral Surgeon) at another time.
4. If a **Lower** tooth is to be removed, or lower jaw or soft tissue surgery is to be performed, temporary tingling or numbness of the lips, chin, cheek, nose, tongue, teeth, and/or gums tissue may occur. This change in sensation may, in some rare instances, be permanent.
5. If a tooth is to be removed, a "Dry Socket" may develop. This is a painful condition that may necessitate returning to the office several times over the course of several weeks for treatment.
6. If a tooth is to be removed, a decision may be made to leave a small piece of root in the jaw when its removal would require extensive surgery that may damage adjacent vital structures such as nerves or sinuses.
7. Injury to adjacent teeth or fillings; breakage of the jaw.
8. Postoperative jaw joint (TMJ) disorders which may require physical therapy, surgery, and other associated treatment modalities.
9. Drug interactions or allergies, cardiac arrest, stroke, paraplegia, quadriplegia, or death.

I understand that during the course of surgery, unforeseen conditions may be revealed that necessitate extension of the procedure or a change in the procedure which was previously described. I authorize Dr. Miller to perform such procedures and am aware that a referral to the Oral Surgeon may be necessary.

I also understand that no guarantees can be made regarding the outcome of the surgery.

If a health care worker is accidentally exposed to my blood or fluids, I give my permission for my blood to be drawn and to have it tested for Hepatitis, Human Immunodeficiency Virus (HIV), and a liver function test. I also give my permission to have any other laboratory tests deemed necessary. I authorize the release of these test results to the facility that processes the blood test, as well as to the exposed person and his or her medical representative. I understand that the results will become part of my medical record. If the results are positive, state law mandates reporting to the MN Department of Health.

I understand that medications given to me either at the office or in a prescription form may cause drowsiness and lack of awareness and/or coordination. I also understand that such drowsiness may be greatly and dangerously increased if I drink alcohol or take other sedative drugs. I understand that I should not operate a vehicle, automobile, or hazardous devices, nor should I make any important decisions while taking prescription medications or until I have fully recovered from the effects of the medicine.

If I have had a general anesthetic or have been given sedation, I understand and agree not to operate any vehicle or hazardous device, nor will I make any important decisions for the first 24 hours after my release from surgery. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery. I will also arrange for a responsible adult to be with me for the rest of the day and the night following my surgery and anesthetic. If I have minor children, I will arrange for a responsible adult to take care of them for the rest of the day and night following my surgery and the anesthetic.

I agree to cooperate completely with the recommendations of Dr. Miller while I am under her care, realizing that failure to do so could result in a less than optimal treatment result and could even be life-threatening.

I certify that I fully have read and understand English and have read, or I have had it explained or translated for me, and I fully understand this consent for surgery.

Please ask the doctor if you have any questions concerning this consent form before signing it.

Patients Signature

Date

Parent or Legal Guardian (if under 18 or mentally Handicapped)

Date

Witness (Translator, if parent or guardian does not understand English)

Date

Doctor

Date