ORAL SURGERY ASSOCIATES
CENTER FOR DENTAL IMPLANTS

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NAME: _____

YOUR SURGERY IS SCHEDULED AT: _____ **ON:** _____

ARRIVAL TIME IS: _____

If you are a child or legally a minor at least one parent or guardian must be with you.

Get a good night's sleep before your surgery.

Good oral hygiene is essential for proper healing. **BRUSH AND FLOSS YOUR TEETH AND RINSE WITH WARM SALT WATER** prior to your surgery.

Once benefit coverage has been determined you will be contacted regarding the amount due at the time of surgery.

INSTRUCTIONS FOR PATIENTS WHO ARE TO RECEIVE SEDATION PRIOR TO ORAL SURGICAL PROCEDURES

With the aid of sedation your oral surgery will not be unpleasant. The medication will be given through a vein in your arm and, in most cases, local anesthesia will also be given.

It is **ABSOLUTELY ESSENTIAL that you bring a responsible adult with you who will be prepared to stay and receive instructions on your care following surgery and care for you the day of surgery. THIS PERSON SHOULD BE PREPARED TO DRIVE YOU TO AND FROM THE OFFICE. YOU MUST NOT DRIVE YOURSELF.**

If surgery is in the morning **DO NOT** eat or drink anything after midnight the night prior to surgery. If your appointment is in the afternoon **DO NOT** eat or drink anything eight (8) hours prior to your surgery. If medication has been prescribed or given to you to take prior to surgery it should be taken with very small amount of water. If you have any questions regarding your routine prescription medication, please contact our office.

You should wear loose fitting, comfortable clothing with short sleeves. Do not wear a tight collar or necktie. Neither false eyelashes nor contact lenses should be worn. Nail polish and acrylic nails need to be removed. Also, you should try to urinate immediately prior to your surgery.

Due to the type of anesthesia that you will be receiving, you should plan on resting at home with someone to assist you for at least the first day.

If you have any questions, please feel free to call our office.

I HAVE READ AND UNDERSTAND THE ABOVE INSTRUCTIONS:

_____ _____
Signature of Patient or Responsible Party Date

_____
Witness

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