

**Oral & Maxillofacial Surgical Specialists, P.C.**

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## **INSTRUCTIONS FOR OFFICE I.V. ANESTHESIA**

### **YOUR SURGICAL PROCEDURE WILL NOT BE PERFORMED IF YOUR ESCORT/DRIVER IS NOT PRESENT AT THE TIME OF CHECK IN**

For those patients that will receive I.V. anesthesia, please follow these very important instructions:

- 1). You must come for your surgery with a completely empty stomach. This means taking no food or fluid (not even water) for at least six (6) hours before your appointment. If you are taking regular oral medications, please specifically ask your Oral & Maxillofacial Surgeon how to manage them on the day of surgery.
- 2). A reliable adult (one per person) must accompany you to take responsibility for your transportation and welfare because the medicine you will receive will diminish your thinking and reflexes. **This person must remain at the office during your surgery (usually an hour) and transport you home immediately thereafter.** It is most important that the attendant watch you carefully for 4-6 hours after the surgery. You should not be allowed to drive or even walk around unescorted because the anesthesia can result in slow reactions.
- 3). Clothing should be short-sleeved and loose-fitting. Do not wear boots.
- 4). Brush your teeth and gums before coming to the office.
- 5). Please wear a minimum of facial makeup. Do not wear nail polish. If acrylic nails are worn, please remove nails on each index finger or surgery **Will Be Rescheduled.**
- 6). There will be a \$125.00 fee charged for patients who do not give a 24-hour cancellation notice.

### **24 HOUR ANSWERING SERVICE (865) 482-1319**

***It is our office policy to require that the escort of any surgical patient remain in the office during the patient's entire stay in our office. Should the escort leave the premises and not be available at the time of the patient's discharge, the following will occur:***

***The patient will be transported to the appropriate hospital via ambulance. They will then be admitted to the hospital for observation. The transport by ambulance as well as the hospital admission will be at the patient's expense.***

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Chart No. \_\_\_\_\_

## Oral & Maxillofacial Surgical Specialists, PC

### CONSENT FOR SURGERY AND ANESTHESIA

I hereby authorize Dr. \_\_\_\_\_ and staff to perform the following procedure:

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and to administer the anesthetic I have chosen, which is:

- local anesthesia       local w/nitrous oxide       I.V. sedation  
 local w/monitors       general anesthesia

- \_\_\_\_\_ 1. With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, TMJ injuries, infection, or small fragments of tooth root which may be left in place to try to avoid damage to structures such as nerves or sinuses.
- \_\_\_\_\_ 2. Lower tooth roots may entangle the nerve of the lower jaw and surgery may result in a numbness of the chin, lip, gums or tongue (including possible loss of taste), which may last for weeks, months, or rarely be permanent. If the upper tooth roots entangle the sinus, a sinus infection may develop, a root tip may enter the sinus, or an opening from the mouth to the sinus may occur, which could require additional surgery. There is also the remote risk of fracturing (breaking) the jaw.
- \_\_\_\_\_ 3. Anesthetic risks include infection, allergic reactions, heart complications, or even death. I understand that giving anesthesia to a person that uses drugs may result in serious or even fatal injury. I realize the need to inform the doctor about any drug use before the anesthetic is given.
- \_\_\_\_\_ 4. If I am to have general anesthesia, I understand that I am to have **no food or drink for six hours** before my appointment. To do otherwise **may be life threatening!**
- \_\_\_\_\_ 5. **I also understand that a responsible adult must drive me home and care for me for several hours after general anesthesia.**
- \_\_\_\_\_ 6. I understand that unusual conditions may be discovered during surgery that will alter the planned surgery. I consent to treatment alterations that are needed to complete the surgery. Because of its nature, no surgical guarantee of results can be given.
- \_\_\_\_\_ 7. Alternative treatments have been explained to my satisfaction.
- \_\_\_\_\_ 8. I give permission for the use of my x-rays or photographs in professional publications or presentations.
- \_\_\_\_\_ 9. (Females) I understand that certain antibiotics could neutralize the effect of birth control pills and allow conception.

I have had an opportunity to have my questions answered and I certify that I can read and understand this form.

\_\_\_\_\_  
Patient's (or legal guardian's) Signature

Date

\_\_\_\_\_  
Witness Signature

Date

\_\_\_\_\_  
Doctor's Signature

Date