Matthew
K.Saxon
DDS,MS

**Matthew K. Saxon
DDS, MS**
—
**Periodontal and Dental
Implant Surgery**

816-651-9683
info@drsaxon.com
drsaxon.com

PALATAL RETAINER INSTRUCTIONS FOLLOWING SOFT TISSUE GRAFTING

01 Wear retainer as much as possible, including overnight, for the first 72 hours following surgery

02 After 3 days without post-surgical bleeding, wear retainer at your discretion. Do not continue to wear overnight

03 Remove retainer when rinsing with mouth rinse

Matthew Saxon

Matthew K. Saxon
DDS, MS
—
Periodontal and Dental Implant Surgery

816-651-9683
info@drsaxon.com
drsaxon.com

PATIENT CONSENT FOR SURGERY, PERIODONTAL THERAPY, AND ANESTHESIA

OTHER PROBLEMS	There are other potential problems that can occur during and after your procedure. These may include, but are not limited to sensitivity to hot or cold, restricted mouth opening, joint pain, bruising, phonetic (speech) interference, gum recession, food impaction between teeth, dry socket, vertigo, etc.
DRUG/ANESTHESIA REACTIONS	You can unexpectedly react to any drug, ranging from a rash to having a life-threatening crisis. If you know of any past allergies, are taking any drugs you have not told Dr. Saxon about, or have any major illness you failed to report, it is imperative you tell us now, or you may be risking your own health.
UNFORSEEN CONDITIONS	I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of Dr. Saxon, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modification in design, materials, or care, if Dr. Saxon feels this is in my best interest.
NO WARRANTY	I understand that if the proposed treatments are successful, the results should include increased long-term retention of teeth, lowering of disease activity, and decreased disease progression. I am aware that periodontitis is a chronic and incurable disease and no guarantee or treatment warranty is expressed or implied. I understand that risk of failure exists, with the relapse and worsening of my present condition always a possibility despite the best of care. I understand that my responsibility in the success of my treatment is vital, and that I must continuously employ the best home care as well as continue with a program of professional maintenance suggested by Dr. Saxon. I also understand that continued and periodic examination and care by my general dentist is vital to my dental health.
PHOTOGRAPHS	I consent to photography, filming, recording, and x-rays of my mouth (oral cavity) and facial structures, as well as their publication, and for use for educational and scientific purposes, provided my identity is not revealed.

I certify that I have read and fully understand the above authorization and informed consent to treatment and the explanations referred to above.

Date ______________ Signature ______________________________

Date ______________ Printed Name ______________________________

Date ______________ Witness ______________________________