



Surgical Patient Records Protocol

In order to allow the participating doctor to receive the most out of the advanced diagnostic and surgical training offered at these courses, protocols are in place. These protocols will provide all participants to view many cases with similar records as well as allow the instructors the ability to screen potential surgical patients for the appropriate course and care.

Participants are required to submit the following records to the course office thirty - (30) days prior to the course.

1. Patient information
 - a. Name, address, phone number
 - b. Physician's name, phone number
 - c. Medical and dental history
 - d. Current medications- dosage and how long on the medication
2. Diagnostic models with maximum intercuspation bite record, ideally mounted on a disposable articulator.
3. Intended Treatment Plan- which includes:
 - a. Diagnosis of the patient's current dental condition
 - b. Surgical Phase
 - c. Restorative Phase
 - d. Maintenance Phase
4. Panorex and/or full mouth radiographic series within past eight months.
5. Full set of photographs or images to aid in diagnosis.
6. Waiver of Risk - send a patient signed copy of your current office version.