ANACAPA ORAL SURGERY
DENTAL IMPLANT CENTER
MARWOOD STOUT, DDS

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Pre-Surgical Instructions

Appointment: ❑ Camarillo ❑ Oxnard Date _____ Time _____

In order to provide you with the highest level of care, we ask that you read and note the following:

1. The night before surgery, take 600 mg of ibuprofen (Motrin or Advil). Do not take this medication if your physician has advised you to avoid ibuprofen or other non-steroidal medications.
2. On the day of surgery, if sedation/anesthesia is planned, **do not consume any food or drink for at least 8 hours prior to your surgery, not even water.** But it is fine to take your medications with just a sip of water.
3. **Take all your prescribed medications at your normal schedule, even if it requires a morning dose** unless Dr. Stout has specified otherwise (**blood thinners and diabetic medications are usually withheld** for your surgery). Avoid alcohol for at least 24 hours prior to surgery. It is best not to smoke for several weeks prior to surgery, as smoking can greatly increase healing problems. Notify the doctor if you have had a change in your health or began any new medication or recreational drug prior to your surgery.
4. Wear loose-fitting clothing with short sleeves. Please leave jewelry and even contact lenses at home. Please remove all piercing jewelry on the face, lips and mouth. Please brush your teeth thoroughly just prior to your appointment.
5. A responsible adult must accompany you to your appointment, register with you at check-in, remain here during your procedure and drive you home. Please do not bring children to wait during the surgery, as most appointments are at least 90 minutes. After surgery, there should be an adult available to assist in your home care.

Appointments, Insurance, and Financial Arrangements:
We accept cash, debit and credit cards, and local checks. Credit cards and outside financing will incur processing fees. A discounted package fee is available for cash and debit transactions if no insurance is involved. Fees for treatment covered by insurance benefits may be substantially higher. If after proceeding with a cash-discounted transaction you later decide to submit to your insurance, your cash discount will be reversed and you will be charged the full and itemized treatment and required to make full copayments due.

We are happy to assist you in submitting your dental insurance claim, but insurance payment is not certain. Your carrier could refuse payment even with a prior written preauthorization. **The estimated non-covered balance is due at the time of your surgery.** If your insurance has not paid within 45 days, any unpaid balance is due from you at that time, even if your insurance claim is still pending. Unpaid balances accrue interest at 1.5% per month. Accounts sent to collections are subject to substantial fees, and there is a $30 fee for returned checks. Professional fee estimates are good for 6 months.

In setting your appointment, we set aside an operating suite, instruments, supplies, and time for doctors and staff to care for you; so it is very important to not miss your appointment. **You will be charged a fee of 25% of your treatment plan if you miss your appointment, cancel or reschedule less than 3 business days prior**, or if you arrive for your appointment exceptionally late, arrive without an empty stomach or suitable escort/driver, arrive unprepared to pay for treatment, or for any other reason do not proceed with your appointed treatment. Appointments can be rescheduled or cancelled by speaking to one of our receptionists, but not by phone message or e-mail.

Amount due at surgery (based on an estimate of your insurance coverage) $_____

Thank you for the opportunity to care for you. Please call us if you have any questions regarding your upcoming treatment. We wish you all the best for a successful surgery and a smooth recovery. Your signature below is not a commitment to proceed, but is an acknowledgment you understand and agree to the terms above. Your insurance coverage is not certain – even with a preauthorization. **Our office has not implied or promised insurance coverage or payment**. **You are personally responsible for all professional fees**.

Patient Signature _____ Date _____