

**ALLODERM TISSUE GRAFT**

## Post – Operative Instructions

## Day of Surgery:

- ☐ For the first 24 hrs post op, ice 10 min on, 10 min off. Not after 24hrs as it will affect healing
- ☐ No activity for remainder of day following appointment & for 24hours later (limit talking, exaggerated mouth movements or facial expressions)
- ☐ **No looking (peeking)** at the site, pulling at your cheek or lips or NO big mouth movements as this could lead to the graft failing.
- ☐ **Do not brush or floss the surgical area until advised by the dentist**
- ☐ Do eat cold & soft foods for the first 24hrs after procedure. After 24hrs, warm soft foods but eat on other side of mouth for 2-3 weeks. Do NOT drink hot liquids.
- ☐ Do not rinse your mouth vigorously
- ☐ Do not drink liquids through a straw
- ☐ Do not smoke or use smokeless tobacco products
- ☐ Do not eat hard, solid foods (peanuts, popcorn, chewing gum, chips etc) for at least two weeks.
- ☐ If swelling or pain increases after 3 days then please contact our office.
- ☐ Apply periosciences AO ProVantage 5x daily with tongue. Use a pea size amount starting evening of surgery & every 3 hrs daily for 1<sup>st</sup> week, then 3x daily until the sutures are removed
- ☐ Do not exercise for 1 week
- ☐ Do drink plenty of liquids ( as long as the previous instructions about liquids are followed)
- ☐ All medications that interfere with clotting such as Aspirin, Vitamin E, fish oils stop for 1 week prior to procedure. Advil and Tylenol are ok to use.
- ☐ No alcohol consumption for 1 week

## Swelling:

Swelling and/or brushing may occur.

Telephone Dr. Cam Brauer (403)-804-8719 or Dr Scott Townsend 403-519-0086. If you experience any of the following symptoms:

- Fever lasting more than 1 day
- Swelling or pain which begins 3 or more days after surgery
- Difficulty breathing
- Excessive bleeding
- Discomfort not controlled by your prescribed medication
- Anything else that concerns you



### Extractions (removal) of Baby Teeth

Why do baby teeth need to be removed?

- When a tooth has been damaged either by infection (from tooth decay or gum disease) or trauma (from a knock or bump) or as requested by your orthodontist.

How is the baby tooth removed?

- The tooth and surrounding area will be numbed by local anesthetic. Once the area is numb the tooth is removed. Your child will be asked to bite down on a piece of gauze to help stop the bleeding and form a clot.

What are the risks of removing a baby tooth?

- Damage to lips and cheeks: child may bite or rub the numbed area without realising the damage it may be causing; children may need to be supervised until the numbness has worn off
- Short term minimal to moderate pain is anticipated and can be remedied by an anti-inflammatory (like Advil based on Dr recommendation)

Uncommon risks and complications include:

- If a baby tooth is lost early, the adult tooth may not be ready to move into position to fill the space; this can result in a loss of space for the adult tooth
- Irritation to the nerves during the extraction can cause permanent or prolonged numbness or tingling sensation to the lip, tongue, cheek, chin, gums or teeth

What happens following removal of my child's tooth?

- Healing usually occurs quickly without complications
- Following removal of the tooth, the anesthetic effect may continue for some hours. Your child's mouth may feel swollen and uncomfortable during this period. Some pain can be expected because the tissues have been disturbed during the tooth removal.

What can I / my child do to help prevent complications following removal of a tooth?

- Avoid eating until the numbness is gone
- Your child must not bite or suck the lip, cheek or tongue while the area is numb
- Chew food on the opposite side of the mouth to the wound for 24hours.

I have had the opportunity to ask questions of my doctor and I consent to the procedure.

\_\_\_\_\_  
Parent / Guardian / Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of patient

\_\_\_\_\_  
Relationship



Bone Graft Consent

This is my consent for Dr. \_\_\_\_\_ to perform the following

Procedure \_\_\_\_\_ for Name: \_\_\_\_\_.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

\*My dentist has explained forms of treatment. I have chosen the bone graft to provide stability for future treatment.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible.

I am aware that each patient heals in a different manner after bone graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

I understand that smoking, drinking alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post operative instructions from my dentist. I will respect appointments and have my bone graft checked as well as have regular checkups and hygiene.

To my knowledge, I have given the proper medical information in regards to my physical and mental states (medications, diseases, syndromes, etc). I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition I have mentioned any abnormal reaction of the gums, skin, any abnormal bleeding, or any condition related to my overall health.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Consent for Gingival Graft**

This is my consent for Dr. \_\_\_\_\_ to perform the following

Procedure \_\_\_\_\_ for Name: \_\_\_\_\_

The dentist and/or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

\*My dentist has explained forms of treatment. I have chosen the "AlloDerm" graft – freeze dried acellular dermal graft.

I have been informed of the risks and complications involved with this surgery, medications and anesthesia. These complications can include pain, swelling, infection, and temporary discoloration of the skin, numbness of the lips, tongue, chin, cheek and teeth, as well as pain that can occur for an undetermined amount of time and in some cases, irreversible. Also, if "AlloDerm" is exposed, I understand that I might notice a bad taste or color change of the membrane. Repositioning of tissues procedure may also be required.

I understand that if I decide not to undertake any treatment, the following complications can occur; worsening of the gingival recession, root cavities, periodontal disease, tooth mobility and sensitivity that may require extraction.

I am aware that **one week prior to treatment that I will stop taking fish oils / vitamin E supplements.**

I am aware that each patient heals in a different manner after graft surgery and my dentist cannot predict with certainty the success or possibility of failure of the procedure based on my medical or oral condition.

\*I understand that smoking, drinkin alcohol, or an uncontrolled blood sugar level can affect the results of the graft. My dentist has told me not to smoke. I will follow the pre and post operative instructions from my dentist. I will respect appointments and hae my graft checked as well as have regular checkups.

To my knowledge, I have given the proper medical information in regards to my physical and mental states ( medications, diseases, syndromes, etc) I have also mentioned the possibility of allergies or unusual reactions to drugs and anesthetics. In addition I have mentioned any abnormal reaction of the gums, skin, any abnormal bleeding, or any condition relation to my overall health.

**I am aware that there is a non-refundable \$500.00 fee for any short notice cancellations. A visa or mastercard number will need to be provided when scheduling the grafting surgery. The fee will be applied if I fail to provide 24hours notice or fail to show for my appointment.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Ph: 403-239-0010 Fax: 403-239-0011 Email: tuscdent@telus.net

Oral Surgery Consent Form  
Dr Cam Brauer DMD &/or Dr Scott Townsend DDS

This is my consent for Dr. \_\_\_\_\_ and any associates to perform the following

Procedure \_\_\_\_\_ for Name: \_\_\_\_\_.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

The doctor has **explained** to me that there are certain potential risks in the treatment plan or procedure. These include:

- Injury to Nerve resulting in numbness or tingling of the chin, lips, cheek, gums and or tongue to the side being treated. This may persist for several weeks, months, or in remote instances, permanently. \_\_\_\_\_ (initial)
- Post operative infection requiring additional treatment.
- Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced or the tooth itself can dislodge into the sinus or an opening may occur into the mouth, which may require additional care.
- Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular joint.
- Injury to adjacent teeth and/or fillings.
- In rare circumstances, medical situation requiring medical personnel and or ambulance can occur.
- Post operative discomfort, swelling, and bleeding that may necessitate several days of recuperation
- Decision to leave a small piece of root in the jaw when it's removal requires extensive surgery or complication.
- Stretching of the corners of the mouth with resultant cracking and bruising
- For patients who receive IV Sedation it is required that they **do not consume food 6 hours prior** to treatment or **beverages 2 hours prior** to treatment. You must rest in an upright position following surgery.

To my knowledge, I have given an accurate report of my health history.

Unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can cause additional side effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

I have also been advised not to smoke for two weeks after the surgery \_\_\_\_\_

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

\_\_\_\_\_  
Patient Signature / Guardian (if under 18 years of age)  
(Print name then sign please)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date



### Consent to Dental Photography

I, \_\_\_\_\_ (patient), authorize

Dr Cam Brauer / Dr Scott Townsend, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and / videos are used my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face shot used for any of the above purposes

Signature: \_\_\_\_\_

(Patient / Guardian)

Date: \_\_\_\_\_



## Graft Post Surgery Care

- Rest:** Always get up slowly from a reclining position. Please keep physical activity to a minimum for 72 hours.
- Medication:** As soon as you arrive home, take tablets or capsules prescribed for discomfort even if it does not hurt. Do not take aspirin or any other drug containing aspirin (*such as Anacin, Empirin, Bufferin or APC*) as they can cause bleeding after surgery. If an antibiotic and/ painkiller has been prescribed, please take all the medication as prescribed. **IMMEDIATELY STOP** taking the medication and call us if any drug causes nausea, itching or a skin rash and/ mild to severe stomach upset.
- Chlorhexidine Rinse:** Only if given - After surgery, teeth and gums in the affected area should be rinsed with chlorhexidine rinse. Use 1 Tablespoon for 30 seconds. Repeat 2-3 times daily for 1 week. Please do not swallow chlorhexidine rinse and avoid rinsing your mouth vigorously.
- Nutrition:** Maintain proper nutrition by choosing soft nutritious food which requires minimum chewing such as homemade milkshakes, smoothies, custards, eggs, cream soups etc. For the first 48 hours avoid hot drinks, hot foods and extremely hard foods.
- Stitches:** **NO PEEKING:** The sutures or stitches which are around and between your teeth will keep the gum tissues in the correct position for the first 3 days of healing. You will be scheduled to remove them
- Bleeding:** Some slight seepage of blood is expected after the surgical procedure. Copious bleeding should **not** occur.
- Smoking:** Heat and smoke can act as an irritant, significantly delaying healing and encouraging bleeding. **Please avoid smoking for 72 hours.**
- Alcohol:** Avoid any alcoholic beverages as alcohol can mix with the medications you are taking and cause a severe overreaction. Alcohol also acts as an irritant and may delay the healing process.
- Problems:** Please do not hesitate to call Dr. Townsend or Dr. Brauer during the day if some complications occur @ 403-239-0010 or after hours you can reach  
Dr. Brauer @ 403-804-8719 or  
Dr. Townsend @ 403-519-0086



**Dental Implant Consent Form**  
**Tuscany Dental Centre - Dr Cam Brauer &/ Dr Scott Townsend**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

My Planned procedure will involve placement of (#) \_\_\_\_\_ implant(s).

\*Please initial each paragraph after reading. If you have any questions, please ask your doctor for clarification.

\_\_\_\_\_ I understand that dental implants are placed in stages. The implant will be placed in the bone and will osseointegrate for 3 months prior to a crown being placed, and up to 6 months if grafting material has been placed.

\_\_\_\_\_ I understand that there will be an incision made inside my mouth for the purpose of placing one or more dental implants in my jaw to serve as anchors to replace a missing tooth or teeth, upon which an abutment and a crown, bridge, or denture will be secured. I acknowledge that the procedure has been explained to my full understanding, including the number and location of implants and the type of implant that will be used. I understand that at a minimum there will be a charge for the implant, the crown, bridge or denture.

\_\_\_\_\_ I understand that in certain circumstances, the surgery may involve additional materials and procedures (grafting with bone or artificial bone substitutes, use of healing membranes and associated fixation devices). The need for those procedures may not be apparent until after the surgery has begun. I understand that additional fees may be charged without financial arrangements being made if additional procedures are deemed to be necessary.

\_\_\_\_\_ Alternative treatment methods such as doing nothing, bridges, or dentures has been explained to me.

\_\_\_\_\_ I Understand the risks and complications of dental implant surgery include, but are not limited to:

\*Post - operative discomfort and swelling that may require several days of at-home recuperation.

\*Prolonged or heavy bleeding that may require additional treatment.

\*Damage to adjacent teeth or roots of adjacent teeth

\*Post-operative infection that may require additional treatment.

\*Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly

\*Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joint.

\*Numbness, tingling, or pain in the chin, lips, cheeks, gums, tongue including possible loss of taste sensation or teeth on the operated side(s). These symptoms may persist for several weeks or months, and in some cases may be permanent.

\*Sinus involvement - the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth, which may require additional care.

\*Bone loss around the implants

\*Implant or prosthesis failure. Rarely, the implant or parts of the structure holding the replacement tooth, or the replacement tooth itself, may fail due to chewing stresses.

\*Rejection of the implant by natural body defenses. (If the implant is lost, it is usually possible to replace it in a later surgery after the bony defect has healed or been bone grafted to achieve adequate bone volume for another implant procedure.

\_\_\_\_\_ No guarantee can be or has been given that the implant(s) will last for a specific time period. I acknowledge that there is the risk for failure, relapse, selective re-treatment, or worsening of my present condition, despite efforts at optimal care.

\_\_\_\_\_ If you are a smoker there is no guarantee that the implant will integrate.

\_\_\_\_\_ Maintenance of the implant site as well as continuing hygiene care /interval will be dependent upon the hygienist's recommendation.

My signature below signifies that all questions regarding this consent have been answered to my satisfaction, and I fully understand the risks involved with the proposed procedures and anesthetic. I certify that I read, and understand English. I herby give my consent for the planned surgery.

Signature of Patient or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date: \_\_\_\_\_



**Informed consent for Crown and Bridge Prosthetics**

Name: \_\_\_\_\_ Procedure: \_\_\_\_\_

I understand that treatment of dental conditions requiring Crowns and/or Fixed Bridge Work includes certain risks and possible unsuccessful results, with even the possibility of failure. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (even though care and diligence is exercised in the treatment conditions requiring crowns and bridgework and fabrication of same, there are no promises of guarantees of anticipated results or the longevity of the treatment).

1. **Reduction of tooth structure:** Tooth preparation will be done as conservatively as practical. In preparation of teeth, anesthetics are usually needed. At times there may be swelling, jaw muscle tenderness or even a resulting numbness of the tongue, lips, teeth, jaws and/or facial tissues which is usually temporary, or very rarely permanent.
2. **Crowned or bridge abutment teeth may require root canal treatment.** Teeth, after being crowned, may develop a condition known as pulpitis or pulpal degeneration. Infrequently, the tooth (teeth) may abscess or otherwise not heal which may require root canal treatment, root surgery, or possibly extraction.
3. **Breakage:** Crowns and bridges may possibly chip or break. Many factors could contribute to this situation such as chewing excessively hard materials, changes in biting forces, traumatic blows to the mouth, or normal chewing function, etc.
4. **Longevity of crowns and bridges:** There are many variables that determine "how long" crowns and bridges can be expected to last. Among these are some of the factors – general health, good oral hygiene, regular dental checkups and diet can all affect longevity. Because of this no guarantees can be made or assumed to be made.
5. **It is a patient's responsibility:** to seek attention from the dentist should any undue or unexpected problems occur. The patient must diligently follow any and all instructions, including the scheduling and attending all appointments. Failure to keep the cementation appointment can result in ultimate failure of the crown /bridge to fit properly and an additional fee may be assessed.
6. **Regular recall & hygiene** therapy needs to be done at Tuscany Dental Centre.

**Informed consent:** I have been given the opportunity to ask any questions regarding the nature and purpose of crown and/or bridge treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks including those listed above and including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize my Dentist to render any treatment necessary and/or advisable to my dental conditions including the prescribing and administering of any medications and/or anesthetics deemed necessary to my treatment.

\_\_\_\_\_  
Signature of Patient\_\_\_\_\_  
Date\_\_\_\_\_  
Signature of Dentist\_\_\_\_\_  
Date



## Intravenous Sedation Authorization

Your proposed dental treatment is to be performed with the use of intravenous sedation. The drug used is Versed, (midazolam). This drug is in the same class as valium. If any problems with these drugs have occurred in the past, it is important that Dr Lovick is informed.

The purpose of IV Sedation is to induce a relaxed, comfortable state for long or difficult dental procedures. The patient **will not** be put to sleep with this procedure, but will be relieved of any anxiety and most recollection of the dental visit will be forgotten.

- Prior to IV Sedation, meals should be restricted to nothing solid consumed for 6 hours nor clear fluid for 2 hours prior to the sedation procedure.
- Wear loose comfortable clothing. Wear short sleeved shirt or long sleeved shirt loose enough to be pushed above the elbow.
- Remove contact lenses prior to the appointment.
- Please do not wear nail polish or lipstick.
- If possible, please arrive at the office at least ten minutes before your scheduled appointment time.
- A BMI (body mass index) of no greater than 34 is permitted to legally proceed with IV sedation at a non-hospital clinic...find yours at [www.bmicalculator.org](http://www.bmicalculator.org)

Most patients are tired and disoriented following sedation; therefore, ALL PATIENTS MUST BE ESCORTED HOME BY A RESPONSIBLE ADULT. THE ESCORT MUST COME TO THE OFFICE to pick up the patient. The **escort must monitor the patient for the first 2 hours following surgery in an upright resting position** and call the office if you notice the bleeding is not slowing. Some patients feel normal following sedation, however, UNDER NO CIRCUMSTANCES CAN A PATIENT OPERATE A MOTOR VEHICLE for the rest of the day. In addition, no alcoholic consumption is advised for 18 hours following IV Sedation.

On arriving home, most patients will fall into a normal sleep for several hours and a mild fever may occur. After a good night's sleep, all symptoms will have subsided and normal activities can be resumed.

**I have read and understand all of the above information and my BMI is: \_\_\_\_\_**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Escorts Name

\_\_\_\_\_  
Escorts Phone #



## **Consent for Root Canal Treatment**

Patient Name: \_\_\_\_\_

I hereby authorize Dr \_\_\_\_\_ and any associates to perform a root canal on tooth / teeth number (s): \_\_\_\_\_

The doctor has explained to me that the purpose of this procedure is to retain the tooth that may otherwise have to be extracted. The doctor has explained to me the treatment and the anticipated results of the treatment. I understand the risks and benefits of the alternatives. I also understand that root canal therapy has a high success rate, but that there are no guarantees. It has been explained to me that there are certain potential risks and these include:

- Inability to completely fill the root canal because the canal is calcified or has a unique curvature (this may require endodontic surgery or extraction of the tooth)
- Instrument separation in the canal
- Infection that may occur and may continue, requiring further endodontic surgery or extraction
- Tooth and/or root fracture that may require extraction
- Post-treatment discomfort
- Temporary or permanent numbness
- Change in the bite or jaw joint difficulty (TMJ problems or TMD)
- Damage to existing fillings, crowns or porcelain veneers
- As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant temporary or permanent numbness of the tongue, lips, teeth, jaws and/or facial tissues

I have had an opportunity to ask questions with my doctor and I consent to the procedure.

\_\_\_\_\_  
Patient / guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship



## Scaling and Root Planing Post Operative Instructions

*Scaling and root planing is a non-surgical treatment of periodontal disease. The purpose of the treatment is to remove bacterial plaque and tartar from around teeth and under the gum line. The goal is to produce clean, smooth teeth and roots, which will promote healing of the inflammation and infection of gum disease.*

- After scaling and root planing, avoid eating anything on the area being treated for two hours or until the dental anesthetic has worn off completely, if used.  
Avoid any hard or crunchy foods such as tortilla chips, potato chips, popcorn, or seeds for the next several days.
  - To help soothe the area, rinse your mouth 2-3 times a day with warm salt water rinses. Use one teaspoon of salt for every 3 ounces of water.
  - Resume your home care regimen immediately, but be gentle with the area recently treated. Do not be concerned if there is mild bleeding during brushing for a few days following the deep cleaning procedure.
  - Refrain from smoking for 24 to 48 hours after scaling and root planing. Tobacco will delay healing of the tissues.
  - You may take a **non-aspirin** pain reliever for any tenderness or discomfort. Take ibuprofen (Advil) or Tylenol unless you are allergic or have medical conditions that prevent taking these medications.
    - 600 mg (equal to 3 tabs of over-the-counter Ibuprofen or Advil) every 4-6 hours if necessary. Do NOT exceed 2400 mg in a 24 hour period!
- OR
- Extra strength Tylenol 1000 mg (equal to 2 tabs of over-the-counter Extra Strength Tylenol) every 4-6 hours if necessary. Do NOT exceed 4000 mg in a 24 hour period!
  - If Prescribed, take all antibiotics until finished, even if feeling fine after a few days. This is an important part of treatment to reverse periodontal disease.
- If you have persistent discomfort or swelling that occurs after scaling and root planing, contact the office for instructions as soon as possible.



**Ph:** 403-239-0010 **Fax:** 403-239-0011 **Email:** tuscdent@telus.net

Tuscany Dental Centre  
2078, 11300 Tuscany Blvd NW  
Calgary AB T3L 2V7  
Ph# 403-239-0010  
Fax: 403-239-0011  
Email: [tuscdent@telus.net](mailto:tuscdent@telus.net)

Date: \_\_\_\_\_

This letter is to request x-rays be released from  
Dr. \_\_\_\_\_

For: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Or authorized Dr Cam Brauer and /or Dr Scott Townsend to forward any requested x-rays

Thank you,

\_\_\_\_\_  
Patient / Parent / Guardian Name