



Pre-Operative Instructions for Dental Treatment SBM Dental Hospital & Implant Center

Advanced Dental Care | Implants | Aligners | Laser Dentistry

To ensure safe, predictable, and comfortable dental treatment, please carefully follow the pre-operative instructions below. These guidelines reduce complications, improve healing, and help us deliver the best clinical outcome.

General Medical Instructions

- Inform the dentist about all medical conditions including diabetes, hypertension, heart disease, thyroid disorders, or allergies.
- Provide a complete list of medications currently being taken.
- Inform if you are pregnant or breastfeeding.

Food & Medication Guidelines

- Eat a light meal 2–3 hours before routine treatment.
- Do not arrive with an empty stomach unless fasting is specifically advised.
- Take prescribed medicines as instructed.

Appointment Preparation

- Brush and floss before visiting.
- Carry previous dental records and X-rays.
- Arrive 10–15 minutes early.

Dental Implant Surgery

- Take prescribed antibiotics or medications as instructed.
- Avoid smoking and alcohol 24 hours prior.
- Wear comfortable clothing and arrange an escort if advised.

Root Canal Treatment (RCT)

- Eat before appointment to maintain comfort during treatment.
- Continue routine medications unless advised otherwise.
- Inform dentist if severe pain or swelling increases before appointment.

Tooth Extraction / Minor Oral Surgery

- Avoid blood-thinning medicines unless cleared by physician.
- Do not smoke before procedure.
- Arrange for someone to accompany you if sedation is planned.

Clear Aligners / Orthodontic Procedures

- Maintain excellent oral hygiene before appointment.
- Bring previous aligners or orthodontic appliances.
- Avoid eating sticky foods before bonding appointments.

Patient Acknowledgment & Consent

I confirm that I have read and understood the pre-operative instructions provided by SBM Dental Hospital & Implant Center. I agree to follow all instructions before my dental treatment and have informed the dentist about my medical history truthfully.

Patient Name: _____

Date: _____

Signature: _____

Doctor Name: _____

Doctor Signature: _____

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