



Soft Food Instructions & Compliance Agreement

Patient Agreement:

This treatment is a high-performance smile that requires care and maintenance.

What's Included:

- Implants: Covered for 4 years (if you follow all instructions)
- Final Teeth: Covered for 3 years (material issues only)
- Adjustments: Covered for 90 days after delivery

Your Responsibilities:

- Attend all follow-up visits 1 day, 1 week, 1 month, 4 months and 6 month
- Complete 2 cleanings in the first 12 months (Complimentary)
- Get 1 cleaning every year following implant surgery (\$400 per visit per arch)
- Brush morning and evening, floss before bed, Waterpik after every meal daily
- Wear your night guard daily

Important:

If you miss visits or do not take care of your teeth, the warranty is void and extra costs will apply.

To protect your temporary dental restorations and prevent damage, it is essential to avoid foods that are hard, crunchy, sticky, or require excessive chewing. During your healing phase, please follow a soft-food diet as outlined below:

Recommended Foods

Breakfast:

Scrambled eggs, smoothies (without seeds), well-cooked oatmeal, yogurt (no chunks), cottage cheese, soft pancakes or waffles.

Lunch/Dinner:

Mashed potatoes, soft pasta, steamed vegetables, pureed soups, soft fish, tofu, moist meatloaf, ground meat dishes, and soft rice dishes.

Snacks:

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Applesauce, pudding, gelatin (Jell-O), soft cheeses, hummus, smooth nut butters, avocado, and soft fruits (peeled and sliced).

Desserts:

Ice cream (without nuts), custard, soft cake, cheesecake (without hard crust), and mousse.

Beverages:

Milkshakes, smoothies, protein shakes, broths, and herbal teas.

Important Tips:

Cut food into small pieces.

- Chew using your back teeth.
- Avoid biting directly into hard foods.
- Stay away from sticky foods such as caramel and gum.

Rule of Thumb:

If you cannot easily cut the food with the side of a plastic fork, do not eat it.

Failure to follow these dietary guidelines may result in damage to your temporary restorations and could require additional treatment or repairs.

Acknowledgment & Signatures

Patient Name: _____

Patient Signature: _____ Date: _____

Office Representative: _____ Date: _____

Dr. Jared Williams, DDS

I understand the dietary restrictions and instructions provided. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

I do not understand the dietary restrictions and instructions. I request additional clarification before proceeding.

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Surgical Revision & Compliance Agreement

Patient Name: _____

DOB: _____

Date: _____

1. Importance of Compliance

Fixed All-on-X treatment requires strict adherence to all post-operative instructions to ensure proper healing, implant integration, and long-term prosthetic success. Failure to follow instructions may result in implant failure, prosthetic fracture or damage, infection, bone loss, and the need for surgical or prosthetic revision.

2. Definition of Non-Compliance

Non-compliance includes, but is not limited to: eating restricted foods during healing; premature chewing on temporary prosthesis; smoking, vaping, or use of nicotine products; failure to maintain proper oral hygiene; missing scheduled follow-up appointments; failure to take prescribed medications as directed; trauma to the prosthesis; grinding or clenching without prescribed appliance; ignoring post-operative restrictions; and poor maintenance of prosthesis and surrounding tissues.

3. Revision Fees Due to Non-Compliance

If revision treatment is required due to patient non-compliance, the following fees will apply:

First Occurrence: \$5,000 per arch. This fee includes surgical revision and sedation.

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These fees apply when implant or prosthetic failure is determined to be related to patient non-compliance.

4. Acknowledgment

I understand that the success of Fixed All-on-X treatment depends heavily on my compliance with all instructions provided by Dr. Jared Williams, DDS. I acknowledge that I have received post-operative instructions, understand dietary restriction understand that smoking and poor hygiene significantly increase failure risk, and understand and agree to the revision fees outlined

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JARED E WILLIAMS
— DDS —

Acknowledgment & Signatures

Patient Name: _____

Patient Signature: _____ Date: _____

Office Representative: _____ Date: _____
Dr. Jared Williams, DDS

- I understand the instructions provided and all questions were answered***
- I need additional clarification before proceeding***

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