

To: Dr. _____

Please complete the form below and return it to
Dr. _____

RE: _____

Date of Birth _____

Phone# _____
Fax# _____

Our patient has presented with the following medical problem(s): _____

The following treatment is scheduled in our clinic: _____

Most patients experience the following with the above planned procedures:

- bleeding: minimal (<50ml) significant (>50ml)
- stress and anxiety: low medium high

Dentist's signature

Date

PHYSICIAN'S RESPONSE

Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, and the history and status of infectious diseases. Ordinarily, local anesthesia is obtained with 2% Lidocaine, 1:100,000 epinephrine. For some surgical procedures, the epinephrine concentration may be increased to 1:50,000 for hemostasis. The epinephrine dose NEVER exceeds 0.2 mg total.

CHECK ALL THAT APPLY

- OK** to **PROCEED** with dental treatment; **NO** special precautions and **NO** prophylactic antibiotics are needed .
- Antibiotic prophylaxis **IS** required for dental treatment according to the current American Heart Association and/or American Academy of Orthopedic Surgeons guidelines.
- Other precautions are required: (please list) _____

- DO NOT** proceed with treatment. (Please give reason) _____

Treatment may proceed on (Date) _____

- Patient has an infectious disease:
 - AIDS (please provide current lab results) Hepatitis, type _____, (acute/carrier)
 - TB (PPD+/active) Other (explain) _____
- Requested relevant medical and/or laboratory information is attached.

Physician Signature

Date

PATIENT CONSENT

I agree to the release of my medical information to the above named dentist office.

Patient Signature

Date