Dental Practice Name

Street Address

City, State Zip Code

PH: _____ FAX: _____

MEDICAL RELEASE FORM

In our continuing efforts to ensure the safety of our mutual patients, we request your response to our questionnaire. Please make any necessary suggestions or comments. If you would like to discuss any particular aspect of the planned treatment, please call and ask for Dr. _____.

PATIENT: _____ DOB: _____

PROPOSED TREATMENT: _____

ANESTHETIC/MATERIALS: _____

SIGNATURE OF DENTIST: _____ DATE: _____

(Please respond and comment when necessary to marked questions)

1. DOES PATIENT'S MEDICAL CONDITION REQUIRE ANY ALTERNATIVE DENTAL TREATMENT? Y ☐ N ☐

COMMENTS: _____

2. DOES PATIENT NEED TO BE PREMEDICATED WITH ANTIBIOTICS? Y ☐ N ☐

IF YES, DRUG OF CHOICE AND DOSAGE _____

3. CAN DENTAL TREATMENT BE ADMINISTERED WITHOUT RISK TO PATIENT'S HEALTH? Y ☐ N ☐

IF NO, WHY NOT? _____

4. CAN LOCAL ANESTHETICS BE ADMINISTERED? Y ☐ N ☐

A. LIDOCAINE 2% WITH EPINEPHRINE 1:100,000 Y ☐ N ☐

B. CARBOCAINE 3% WITHOUT EPINEPHRINE Y ☐ N ☐

C. CITANEST 4% WITHOUT EPINEPHRINE Y ☐ N ☐

5. PLEASE LIST MEDICATIONS WITH DOSAGES AND SIDE EFFECTS (ATTACH ADDITIONAL SHEETS IF NEEDED)

_____

6. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THE PATIENT'S HEALTH THAT WOULD BE RELEVANT TO DENTAL TREATMENT? Y ☐ N ☐

IF YES, WHAT? _____

_____

PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____