320 Midland Parkway, Suite A | Summerville, SC 29485 | 843-203-5043 | delitedental.net

Date: ____________________ ATTN: ___________________________

Patient Name: ____ DOB: ______/______/__________

Dear Dr. _________________________

Our Mutual Patient is scheduled for dental treatment that may include any of the following procedures:

__Cleaning (Simple or Deep)

__Radiograph

__Fillings, Crowns, Bridges

__Extraction (Simple or Surgical)

__Root Canal Therapy

__Local Anesthetic (with epinephrine)

__Nitrous Oxide

__Other: _________________________________

The patient has indicated the following medical conditions: ____

____

Please evaluate this patient's medical history and advise us of any special considerations that should be made.

Antibiotic Prophylaxis: Yes__ No__

Interruption of Anticoagulants: Yes__ No__

How long before and after treatment?

____

Anesthetic Restrictions: Yes__ No__

Is epinephrine OK? Yes__ No__

Type of antibiotic allowed /recommended: _______________________

Any additional comments? ____

Physician (Print) _________________________________

Physician Signature ____

We appreciate your assistance in providing optimum care for this patient.