delite dental

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.