FAMILY DENTISTRY AND DENTAL SPECIALIST GROUP

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4250 TOWN CENTER BLVD
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Date: _____

Patient Name: _____ Telephone Number: _____

Date of Birth: _____ Social Security Number: _____-____-_____

Physician's name: _____ Contact Phone Number: _____

Fax Number: _____

Planned dental procedures may include x-rays, subgingival cleanings, fillings, root canals, extractions.

IS THE PATIENT AN ACCEPTABLE CANDIDATE FOR THE ABOVE PROCEDURE?

☐ YES ☐ NO

SHOULD PROPHYLACTIC ANTIBIOTICS BE PRESCRIBED?

☐ YES ☐ NO

IF YES, WHICH ONES? _____ DISPENSE: _____

CAN LOCAL ANSTHESIA WITH EPINEPHRINE (1:100,000) BE USED?

☐ YES ☐ NO

IF THE PATIENT IS TAKING ANTICOUGLANT DRUGS: (EXAMPLE: PLAVIX, COUMADIN, EXT.)

ANTICOUGLANT MEDICINE CAN BE DISCONTINUED _____ DAYS BEFORE THE DENTAL PROCEDURE AND RESUMED WITHIN ____ DAYS AFTER THE DENTAL PROCEDURE.

ANY OTHER PRECAUTIONS TO BE TAKEN:

_____

_____

_____ _____

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PHYSCIAN SIGNATURE DATE