Dental Care Center

Harrold and Associates

To:		From:	Dental Care Center- Free Dental Day
Fax:		Date:	
Phone:		Pages:	
Re:		CC:	

Patient Name ______________________ **Date of Birth** ______________

Please complete the following information and fax back to our office as soon as possible.

****Without this information, we will be unable to treat the patient****

Pins/Plates/Screws/Artificial Joints * Heart Problems/ Murmurs

Does this patient require pre-medication prior to dental treatment? YES____ NO____

Blood Thinners

What type of blood thinner has this patient been prescribed? ______________________

May this patient undergo general dentistry procedures wile taking the above listed medication? Yes ____ No ___

How many days does this patient have to be off if the above listed medication prior to dental extractions? ____________________

Pregnancy

Is elective dentistry recommended during gestation? Yes____ No______

Is this patient able to receive x-rays? Yes ___ No ___

Is this patient able to receive lidocainee &/or septocain as local anesthesia? Yes___ No___

Is this patient able to receive extractions? Yes___ No___

What types of pain medications may be administered? _____________________________

What types of antibiotics may be administered? ___________________________________

Doctor Signature: ____

This material contains privileged and confidential information intended only for the addressee. If the reader of this message is not the intended recipient, you are notified that any dissemination, disclosure, distribution or copying of this transmission is prohibited. Should you receive this communication in error, we would greatly appreciate you contacting us at the above number. Thank you.