# FAMILY DENTISTRY AND DENTAL SPECIALIST GROUP

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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: _____

_____

_____ _____

PHYSCIAN SIGNATURE DATE