Style Your Smile Family and Cosmetic Dentistry

46 Village Court, Hazlet, NJ 07730 Tel: 732-335-553

Medical Consultation

Patient Name: _____ DOB: _____

Dear _____,

The above named person is a patient at our dental office. We need to consult with you regarding the following matter(s). Please review the checked areas below, write your recommendations, and return to our office as soon as possible to prevent delays in treatment. Thank you so much for your time and attention.

_____ Does this patient require subacute bacterial endocarditis prophylaxis?

_____ Yes _____ No

_____ This patient was unable to provide an accurate and thorough medical history. Please provide a full health history plus a current medication list.

____Do you feel that the patient can tolerate the following procedures without serious or undue complications?

_____

_____ Yes _____ No Comments:

Other consult:

Please fax this completed form to:

_____	_____	_____
Physician name	Physician Signature	Date

_____	_____	_____
Dentist Name	Dentist Signature	Date