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MEDICAL RELEASE FORM

In our continuing efforts to ensure the safety of our mutual patients, we request your response to our questionnaire. Please make any suggestions or comments you may have. If you would like to discuss particular aspects of the planned treatment, please call and ask for Dr. Christine Sie. Thank you.

Signature of Dentist: ______________________________ Date: ____________________

Patient Name: ____

Medical History: ____

Dental Diagnosis: ____

ف YES ف NO Does patient's medical history or condition require any alternative treatment?

ف YES ف NO Does patient need to be pre-medicated with antibiotics?

If yes, dosage: ____

ف YES ف NO Can dental treatment be administered to patient without risk to patient's health?

ف YES ف NO Is patient contagious at this time?

ف YES ف NO What antibiotic and pain medication can we prescribe to patient?

Rx ____

ف YES ف NO Can local anesthesia be administered to patient?

Lidocaine 2% with epinephrine 1:100,000	ف YES	ف NO
Marcaine 0.5% with epinephrine 1:200,000	ف YES	ف NO
Carbocaine 3% without epinephrine	ف YES	ف NO

ف YES ف NO Is there anything else we should know about patient's health that would be significant to dental treatment? ____

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Physician: ______________________________ Phone: ____________________

Address: ______________________________ City: ____________________ Zip: ____________

Signature of Physician: ______________________________ Date: ____________________