Murrells Inlet Dental Group

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Our mutual patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

is scheduled for dental treatment. Treatment may include:

\_\_\_\_\_ Cleaning (simple or deep)

 \_\_\_\_\_ Radiographs

 \_\_\_\_\_ Nitrous Oxide

 \_\_\_\_\_ Local Anesthetic (with epinephrine)

\_\_\_\_\_ Fillings, Crowns, Bridges

\_\_\_\_\_ Root Canal Therapy

 \_\_\_\_\_ Extractions (simple or surgical)

 \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient has indicated the following medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please evaluate this patient’s medical history and advise us of any special considerations that should be made. Antibiotic prophylaxis: ❏ Yes ❏

No Interruption of anticoagulants: ❏ Yes ❏No

How long before and after treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthetic restrictions: ❏ Yes ❏No Is Epinephrine OK? ❏ Yes ❏No

Type of antibiotic allowed/recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pain mediation allowed/recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We appreciate your assistance in providing optimum care for our patient. Please sign and fax form to:

Murrells Inlet Dental Group 912 Inlet Square Drive Murrells Inlet, SC 29576 Phone #: 843-651-9009 Fax #: 843-651-9846 murrellsinlet@carolinadentalalliance.com