Playtime Dental
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Mansfield OH 44906
www.playtimedental.com

Jackson Cockley DDS
General Dentist
Ph: 419.774.PLAY (7529)
Email: contact@playtimedental.com

MEDICAL CONSULTATION REQUEST

To: Dr. _____

_____

RE: _____

Please complete and return this form. Thank you.

Our fax number: 419-774-7529

Date of Birth _____

Our patient reports the following medical condition(s): _____

_____

The following treatment is scheduled in our office: _____

_____

Most patients experience the following with the above planned procedures:

Bleeding: _____ minimal _____moderate _____significant

Stress and anxiety: _____low _____medium _____high

Dentist's signature _____ Date _____

PHYSICIAN'S RESPONSE

Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, and the history and status of infectious diseases. Ordinarily, local anesthesia is obtained with 2% Lidocaine, 1:100,000 epinephrine. For some surgical procedures, the epinephrine concentration may be increased to 1:50,000 for hemostasis. The epinephrine dose NEVER exceeds 9.2 mg total.

CHECK ALL THAT APPLY

____ **OK** to **PROCEED** with dental treatment; **NO** special precautions and **NO** prophylactic antibiotics are needed.

____ Antibiotic prophylaxis **IS** required for dental treatment according to the current American Heart Association and/or American Academy of Orthopedic Surgeons guidelines.

_____Physician will prescribe necessary antibiotic

_____Physician recommends the following antibiotic to be written as :_____

_____

____ Other precautions are required: (please list) _____

____ **DO NOT** proceed with treatment. (Please give reason)_____

Treatment may proceed on (Date)_____

____ Patient has an infectious disease:

_____AIDS (please provide current lab results) _____Hepatitis, type _____, (acute/carrier)

_____TB (PPD+/active) _____Other (explain)_____

____ Requested relevant medical and/or laboratory information is attached.

Physician's Signature _____ Date_____

PATIENT CONSENT

I agree to the release of my dependent's medical information to the above named dental office.

Parent Signature _____ Date_____