



Playtime Dental
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Jackson Cockley DDS
General Dentist
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MEDICAL CONSULTATION REQUEST

To: Dr. _____

Please complete and return this form. Thank you.

Our fax number: 419-775-9339

RE: _____

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 _____