5004 Ferrell Pkwy, Ste 104
Virginia Beach, VA 23464
Ph: 757-296-0570 Fax: 757-296-0571
Email: info@smilingwithlove.com

MEDICAL CONSULTATION FORM

Patient Name: __________________________ DOB:______________ Today's Date:____________________

We are planning dental treatment for this patient with our pediatric dental office.
Our records indicate a medical history of:

____

____

Please Evaluate the patient and report your findings below accordingly:

Past Medical History

____

____

Allergies:

____

____

Current Medications and Dosages:

____

PLEASE ANSWER YES OR NO FOR ALL THE QUESTIONS BELOW:

Are there any contraindications to the use of local or general anesthesia? No ____Yes ____
Are there any contraindications to the use of nitrous oxide? No ____Yes ____
Does the patient require antibiotic prophylaxis prior to treatment? No ____Yes _____
Are there any contraindications to the use of lidocaine with epinephrine for dental treatment? No ____Yes ____
Are there any contraindications for dental fillings/crowns/extractions/regular routine care? No ____Yes ____

If yes to any of the above, please indicate why:

____

____

Physicians Signature: ____Date: ______________

Physician's Name (Print): ____

Office Phone #: ____Fax #: ______________

Please FAX or EMAIL this completed form to Smiling with Love Pediatric Dentistry.