SHAHRAM SHEKIB, DDS, FAGD, PC

LASER AESTHETIC SURGERY • PORCELAIN VENEERS • INVISALIGN • IMPLANT DENTISTRY

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Medical Evaluation Request

Dear Dr. ____

Your patient, Mr. / Mrs. ________________________________DOB:____________
presented in our office for Dental Care and/or Minor Surgery.

Would you please help us to verify the Medical History of any of the following:

_?_ High Blood Pressure	_?_ Kidney Disease / Dialysis	_?_ Diabetes
_?_ Heart Murmur / MVP	_?_ Hepatitis	_ ? _Pregnancy
_?_ Myocardial Infarction	_?_ Lung Disease	_?_ HIV
_?_Cerebral Vascular Accident	_?_ Prosthetics	_?_ Other________

Please medically evaluate the patient for restorative dental care / or minor oral surgery and answer all checked questions:

1. List medication(s) the patient is presently taking: ______________________
   ____
2. Is the patient on any Blood Thinner Medication(s)? _____________________
   If so, does the patient need to stop the medication(s)?_____________________
   For how many days? ____
3. Must patient have prophylactic antibiotic prior to dental treatment? __________
   If so, what? ____
4. Date and results of last blood chemistry for hepatitis: ____________________
5. May we use a local anesthesia with epinephrine? ______________________
6. Do you, at this time, find any contraindications for restorative dental and / or minor oral surgery? If so, what? ___________________________________

Physician's Name (Please print) :____
Address: ____
Telephone Number: ____
Signature: ____
Stamp or Letter Head: ____