

Golnick Pediatric Dental Associates

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Dear Dr. _____ Date _____

Our mutual patient, _____, DOB _____, presented to our office for dental treatment. A review of the medical history revealed the following conditions:

We plan on performing the following treatment:

We also plan on using the following:

- | | |
|--|---|
| <input type="checkbox"/> Nitrous oxide | <input type="checkbox"/> Vistaril or Atarax (with or without nitrous oxide) |
| <input type="checkbox"/> Valium, Ativan, or Versed (with or without nitrous oxide) | <input type="checkbox"/> Chloral Hydrate (with or without nitrous oxide) |
| <input type="checkbox"/> Local anesthesia | <input type="checkbox"/> Immobilizations (Passive restraints) |

Physician Only Complete This Section

1. Does this patient require antibiotic premedication before treatment due to immunosuppression, organic heart condition, etc.? **YES NO** (If yes, what medication and dosage would you like to prescribe?)

2. Are there any contraindications to the proposed treatment? **YES NO** (If yes, please explain):

3. Do any current medications need to be adjusted, supplemented or suspended for dental treatment? **YES NO** (If yes, please explain):

4. Can this patient safely receive dental treatment, including sedation and restraint? **YES NO**

5. Can this patient safely receive local anesthetic (xylocaine)? **YES NO**

6. Do you feel this patient would best be treated in a hospital setting with general anesthesia? **YES NO** (If yes, please explain): _____

Physician Name _____ Date _____

Physician Signature _____ Office Phone _____

Office Address _____

Should you have any questions regarding the completion of this form, please contact our office as soon as possible. Thank you for your cooperation in treatment.