REQUEST FOR MEDICAL CLEARANCE PRIOR TO DENTAL PROCEDURE WITH CONSCIOUS SEDATION

*The following patient is scheduled to have dental treatment performed under conscious sedation. This form should be attached to the patient's History and Physical. **Patient must be seen within 30 days from dental procedure**. Please **FAX** this form to Dr. Deidra Rondeno at **(404) 942-0088**. Please call (404) 942-0086 if you have any questions or require additional information. Forms are due in our office ONE WEEK PRIOR TO APPOINTMENT.*

Patient: ____ ***DOB:*** ___________

Proposed procedure: ____

Date of proposed procedure: ____

This patient has been examined by me and is deemed suitable for medical clearance for the above listed procedure under conscious sedation.

____
MD Signature

____
Date

Office Phone: ________________________ ***Fax:*** ________________________

For Office Use Only

Date: _________________ ***Time:*** _________________ ***ASA:*** *I II III*

Patient has been reassessed and is an appropriate candidate for Conscious Sedation.

______________________________***MD*** ___________________________***DDS***

PRE-OPERATIVE MEDICAL HISTORY & PHYSICAL EXAMINATION	PATIENT'S NAME: ______________________________ DATE OF BIRTH: ____/_____/________ DATE OF VISIT: ____/_____/________

***** ALL sections of the form MUST be completed*****

PRE- OPERATIVE MEDICAL HISTORY

Past Medical History: ____

Current Medications: ____

(Please list all current medications)

Allergies: ____

Diagnosis (specific systemic problems): ________________________________

***** It is important to complete ALL sections *****

PRE- OPERATIVE PHYSICAL EXAM

Chest and Lungs:	Temp:
	BP:
Cardiovascular:	Pulse:
	Resp:
Neurological:	Weight:
Renal:	***Females ONLY***
	Pregnancy test: yes ◯
Hepatic System:	no ◯
	Would doctor like blood drawn while patient is sedated? Yes ◯ No ◯
Gastrointestinal:	
Mental Status:	

Recommendations /Plans/Medications:

______________________________________ ____________________

Physician's Signature: *Date:*