



MEDICAL CONSULTATION REQUEST FORM

Date _____

Patient Name _____

Patient D.O.B. _____

Patient Identification or S.S. # _____

Patients: Please bring this form into your primary care doctor to be reviewed and signed prior to your necessary dental appointment. Your doctor should review your medical history and make any suggestions regarding current or anticipated medications as they apply to your necessary dental care in our office. Please bring or mail this form to us prior to your scheduled appointment. Thank you

Primary Care Physician: Our mutual patient listed above has been given this form for you to fill out. Please review his/her medical history and current medications and make any recommendations that you deem necessary as it applies to general dental care. Thank you for your assistance. The following treatment is planned.

Primary Care Physician Suggestions:

Signed _____ Date _____