

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: _____