

MEDICAL HISTORY VERIFICATION

Patient's Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

PLEASE  
RETURN BY  
\_\_\_\_\_

Dear Doctor,

The above patient is scheduled for implant oral surgery. Surgery will be performed on an outpatient basis with conscious sedation being provided by oral drugs. Please verify and/or provide the following medical information, and indicated any contraindications to the medications we will be prescribing.

Date of most recent physical \_\_\_\_\_

Significant medical or psychological problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Results of SMA-12/60 (or comparable) Normal----Abnormal \_\_\_\_\_  
Comments \_\_\_\_\_  
\_\_\_\_\_

PT: \_\_\_\_\_ PTT: \_\_\_\_\_  
CBC Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Comments: \_\_\_\_\_  
Urinalysis Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Comments: \_\_\_\_\_

Medications to be prescribed:

Antibiotic \_\_\_\_\_ Sedation Medication \_\_\_\_\_  
Pain Med. \_\_\_\_\_  
Vitamins \_\_\_\_\_

Contraindications and recommended alternatives: \_\_\_\_\_  
\_\_\_\_\_

The above patient has an acceptable medical history for outpatient oral surgery. Yes \_\_\_\_\_ No \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date