



Dentist Anesthesiology
Ralph Epstein, DDS
Jane Yi, DDS

***DISTINCTIVE DENTAL SERVICES
OF NEW YORK, P.C.***

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300 GARDEN CITY PLAZA
SUITE 100
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VOICE (516) 294-6288
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MEDICAL EVALUATION FOR SEDATION OR GENERAL ANESTHESIA

PATIENT: _____

PHYSICIAN: _____

DATE OF PROCEDURE: _____

Dear Dr.

The above patient is scheduled for _____ with the aid of sedation and/or general anesthesia. Please provide us with the following medical evaluation and any other pertinent information you feel is important in providing optimal care for this patient.

After completing this form, please fax it to our office and ask the patient or guardian to bring the original copy to our office. Thank you for your cooperation and if you have any questions, please feel free to call our office.

If you would like us to take blood samples for laboratory tests while the patient is receiving general anesthesia, please write in detail the tests you would like. Also, please provide us with your Quest identification number and the appropriate ICD-9 number(s).

Sincerely yours,

Ralph Epstein, DDS
Jane Yi, DDS
Dentist Anesthesiology

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Patient: _____

Physician: _____

Date of Procedure: _____

Physician's Phone: _____

Date of Birth: _____

Age: _____

History: (-) if negative

(+) if positive

Allergies _____

Previous Surgery _____

Asthma _____

Previous Surgical Complications _____

Pulmonary Disease _____

Recent Exposure to Varicella _____

Diabetes _____

Sickle Cell Anemia or Variant _____

Heart Murmur _____

Other Hematologic Abnormalities _____

Heart Disease _____

Family History of Bleeding, Muscle Disease, or Anesthesia

Other Conditions _____

Complications _____

Immunizations to date? Yes _____ No _____

Recent ASA _____

Medications? Yes _____ No _____

List dose and schedule

Physical Examination:

Temp. _____ Pulse _____ Resp. Rate _____ BP _____ Hgt. _____ Weight _____

(-) if negative/normal

(+) if abnormal, explain below

Mental Status _____

Throat _____

Lungs _____

Skin _____

Dentition _____

Abdomen _____

Eyes _____

Neck _____

Extremities _____

Ears _____

Chest _____

Back _____

Nose _____

Heart _____

Genitalia _____

Neurological _____

Lab Data:

Hct _____

Hgb _____

Urinalysis _____

Other _____

Summary of Findings:

Suggestions Prior to Surgery:

1. _____

2. _____

_____, M.D.

_____, M.D.

Print Name

Signature

Date _____