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

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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  
Dentist Anesthesiologist

Mary George, DMD/Pediatric Dentistry  
Paul Elkin, DDS/Pediatric Dentistry  
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Patient: \_\_\_\_\_

Physician: \_\_\_\_\_

Date of Procedure: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

**History: (-) if negative**

Allergies \_\_\_\_\_

Asthma \_\_\_\_\_

Pulmonary Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Murmur \_\_\_\_\_

Heart Disease \_\_\_\_\_

Other Conditions \_\_\_\_\_

Immunizations to date? Yes \_\_\_\_\_ No \_\_\_\_\_

Medications? Yes \_\_\_\_\_ No \_\_\_\_\_

List dose and schedule

**(+) if positive**

Previous Surgery \_\_\_\_\_

Previous Surgical Complications \_\_\_\_\_

Recent Exposure to Varicella \_\_\_\_\_

Sickle Cell Anemia or Variant \_\_\_\_\_

Other Hematologic Abnormalities \_\_\_\_\_

Family History of Bleeding, Muscle Disease, or Anesthesia

Complications \_\_\_\_\_

Recent ASA \_\_\_\_\_

**Physical Examination:**

Temp. \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. Rate \_\_\_\_\_ BP \_\_\_\_\_ Hgt. \_\_\_\_\_ Weight \_\_\_\_\_

**(-) if negative/normal**

Mental Status \_\_\_\_\_

Skin \_\_\_\_\_

Eyes \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Throat \_\_\_\_\_

Dentition \_\_\_\_\_

Neck \_\_\_\_\_

Chest \_\_\_\_\_

Heart \_\_\_\_\_

**(+) if abnormal, explain below**

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Extremities \_\_\_\_\_

Back \_\_\_\_\_

Genitalia \_\_\_\_\_

Neurological \_\_\_\_\_

**Lab Data:**

Hct \_\_\_\_\_

Hgb \_\_\_\_\_

Urinalysis \_\_\_\_\_

Other \_\_\_\_\_

**Summary of Findings:**

**Suggestions Prior to Surgery:**

1. \_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_, M.D.  
Print Name

\_\_\_\_\_, M.D.  
Signature

Date \_\_\_\_\_