Ralph H. Epstein, DDS
Dentist Anesthesiologist

DISTINCTIVE DENTAL SERVICES OF NEW YORK, P.C.

173 EAST SHORE ROAD
SUITE 201
GREAT NECK, NY 11023
VOICE (516) 487-8110
FAX (516) 487-8394

MEDICAL EVALUATION FOR SEDATION OR GENERAL ANESTHESIA

PATIENT: _____

PHYSICIAN: _____

DATE OF PROCEDURE: _____

Dear Dr.

The above patient is scheduled for dental treatment 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.

Sincerely yours,

Ralph H. Epstein, DDS
Dentist Anesthesiologist

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DDSNY,PC

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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 _____