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

Dentist Anesthesiologist

Ralph Epstein, DDS
(516) 459-5134

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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_____