



Dear _____,MD Date of Request: _____

Patient Name: _____ Patient DOB: _____

Our mutual patient presented to our office for comprehensive dental care. This may include dental cleaning, radiographs, fillings, root canals, dental restorations or extractions and may require the use of local anesthesia and/or Nitrous Oxide. Please evaluate his/her medical condition and report back to us, in writing, with the following information:

*****TO BE COMPLETED BY THE PHYSICIAN*****

Name of Reporting Physician: _____ Date of Report: _____

Address of Reporting Physician: _____

Phone No. of Reporting Physician: (____) _____

1. List of Known medical conditions: _____

2. List of all current medications: _____

3. List of Known Allergies: _____

4. Are there any special precautions or contraindications to dental treatment?
(please be as specific as possible): _____

5. Does this patient require antibiotic prophylaxis prior to dental treatment? Yes or No
If yes, please specify: _____

6. Do you feel this patient can be safely treated in the dental setting? Yes or No

Signature of Physician: _____

Loren C. Buonocore, DMD



Natasha A. Larson, DMD

As the reporting physician, please either use this form or send your own information. For your convenience, you may fax your response to (212) 243-5435. If you have any questions, please call Dr. Loren Buonocore or Dr. Natasha Larson at (212) 243-5437.

We appreciate your timely response to this request so that the patient can commence treatment.

Thank you for your time and attention to this matter.

Parent/Legal Guardian was informed that we requested medical information and gives you permission for release of medical information requested.

Name of parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____