HOW®

HEALTH *through* ORAL WELLNESS®

DELTA DENTAL®

Consultation Form for Pregnant Women to Receive Oral Health Care

Patient Information

Referral / Consultation Request to	Date

Patient Last Name	Patient First Name

Date of Birth	Estimated Delivery Date	Week of Gestation Today

Known Allergies / Medical History

Precautions / Recommendations:

☐ None ☐ Specify (if any):

This patient may have routine dental evaluation and care, including but not limited to:

- ☐ Oral health examination
- ☐ Dental prophylaxis
- ☐ Scaling and root planing
- ☐ Extraction
- ☐ Dental x-ray with abdominal and neck lead shield
- ☐ Local anesthetic with epinephrine
- ☐ Root canal
- ☐ Restorations (amalgam or composite) filling cavities

Patient may have: (Check all that apply)

- ☐ Acetaminophen with codeine for pain control
- ☐ Alternative pain control medication: (specify)
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Clindamycin
- ☐ Cephalosporins
- ☐ Erythromycin (not estolate form)

Prenatal Care Provider	Phone

Signature	Date

PLEASE DO NOT HESITATE TO CALL WITH QUESTIONS

Dentist's Report (for the Prenatal Care Provider)

Diagnosis

Treatment Plan

Name	Phone	Date

Signature of Dentist