HEALTH *through* ORAL WELLNESS®

Dental Patient Medical Consultation Form

Patient Information

First Name	Middle Initial	Last Name

Mailing Address, City, State, ZIP

Phone Number	Email Address

Consult Requested by:

Office Phone Number	Office Fax Number	Office Email Address

☐ Patient scheduled for medical consult:	Appointment Date	Appointment Time

☐ Patient will call to schedule an appointment

Medical Evaluation Request

Dear Medical Colleague: Please evaluate this patient and provide any medical information that will assist us in providing dental treatment as described below. Dental treatment may be delayed pending your written recommendations. Thank you for your prompt return of this consult.

The patient presents with the following oral diagnoses:

- ☐ Gingivitis
- ☐ Periodontal disease
- ☐ Dental caries
- ☐ Infection or other pathology (Differential Diagnosis):
- ☐ Dentures
- ☐ Impacted teeth
- ☐ Hyposalivation/xerostomia

☐ Other findings, comments:

Dental treatment planned:

Medical reason for evaluation:

- ☐ Diabetes Mellitus
- ☐ Hypertension: BP ____/____ Date:
- ☐ Heart murmur
- ☐ Cardiovascular disease
- ☐ Bisphosphonate therapy
- ☐ Pregnancy
- ☐ Joint replacement
- ☐ Anticoagulant therapy
- ☐ Other (describe below)

Dentist Signature	Date

Please complete medical evaluation on the reverse of this form

Form No. HOW-DPMCF Rev. 012015

Patient Authorization to Release Medical Information

I hereby authorize release of my medical information to the dental office requesting this consultation.

Patient Signature	Date

Medical Evaluation Report

Evaluation findings:

Laboratory results (HbA1c, PTT, INR etc.):

Medical contraindication to proposed treatment:

Recommendations/follow up:

Evaluation completed by (print)

Office Phone Number	Office Fax Number	Office Email Address

Provider Signature	Date