



DC Perio & Implants

— PLLC —

Patient Name: _____ Phone: _____ E-mail: _____

Patient Address: _____

Consult requested by: _____ Date: _____

Office Phone Number: _____ Office Fax: _____ Office E-mail: _____

☐ Patient scheduled for medical consult: Date: _____ 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

☐ Dentures

☐ Impacted teeth

☐ Hyposalivation/xerostomia

☐ Infection or other pathology (Differential Diagnosis):

Other Findings, Comments:

Dental Treatment Planned:

Medical Reason for Evaluation:

☐ Diabetes Mellitus

☐ Pregnancy

☐ Hypertension: BP _____ / _____ Date: _____

☐ Joint replacement

☐ Heart murmur

☐ Cardiovascular disease

☐ Bisphosphonate Therapy

☐ Anticoagulant therapy

☐ Other (describe below)

Dental Patient Medical Consultation _____

Dentist Signature _____ Date: _____

Please complete medical evaluation on the reverse of this form



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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: _____ E-mail: _____

Provider Signature: _____ Date: _____