Simply Special Dental of Voorhees
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Fax: 856-702-0856
Phone: 215-764-7224

Must be completed by Physician

Patient's name:_____D.O.B_____Age:_____

Diagnosis:_____Procedure Date:_____

Planned Procedure: Dental rehab: exam, x-rays, scaling & possible extractions, restorations Crowns and root canals.

Immunizations up to date? Yes/ No Provide a copy of immunization record

List of current medications:_____
_____
_____
_____
_____

Allergies (include food and latex) and specific reactions:_____
_____
_____

Previous Surgeries:_____
_____
_____
_____

Physical Exam:

Weight:_____Kg/lbs Height:_____cm BMI:_____

BP:_____ HR:_____ Temperature:_____

Patient"s name_____**D.O.B:**_____

Medical & Surgical History **Details of Positive Findings:**_____

Y___ N___ Previous surgery?_____
Y___ N___ Previous anesthesia?_____
Y___ N___ Prolonged intubation period?_____
Y___ N___ History of Asthma?If so last episode date:_____
_____
Y___ N___ Other Respiratory conditions:_____
_____
Y___ N___ Cardiovascular system conditions?_____
_____
Y___N___ G.I system conditions?_____
Y___N___ Kidney/renal system disorders?_____
Y___N___ Liver & biliary disorders?_____
Y___N___ Hematological disorders?_____
Y___N___ Endocrine & metabolic disorders?_____
_____
Y___N___ Neurological, Neuromuscular,or CNS disorders?_____
_____
Y___N___ Seizures, If yes, last episodes?_____
Y___N___ Behavioral autism, learning disabilities_____
Y___N___ Intellectual disability?_____
Y___N___ Neoplastic disorders? (tumor,cancer)_____
Y___N___ Autoimmune disorders?_____
Y___N___ History of MRSA, C-diff,VRA, HIV, Hepatitis?_____
_____
Y___N___ History of COVID 19? When?_____
Y___N___ Family history of any problems with anesthesia?_____
_____

HEENT:_____

Lungs:_____

Heart:_____

Abdomen:_____

Extremities:_____

Mental status/Neurological:_____

Patient's name_____D.O.B_____

Laboratory Results(as indicated clinically)_____

_____

_____

Impression, recommendations/evaluations:_____

_____

_____

_____

_____

_____

Cleared for dental procedure under general anesthesia? Yes_____ NO_____

Physician name printed_____

Physician signature:_____ Date:_____

Physician phone:_____Physician fax:_____

Physician Email :_____

Physician address:_____