MEDICAL RELEASE FOR DENTAL TREATMENT

Patient Name: ____________________ Patient DOB: ___/____/____ Todays Date___/____/____

I examined your patient on the above date and recommend the following dental treatment:

Before proceeding we want to ensure the patient can be treated safely. Your patient indicated that he/she has the following medical conditions:

In your opinion are there any contraindications to performing the needed dental treatment?

Do you recommend pre-medication for this patient and if so, what type?

Other recommendations or instructions:

Please fax or e-mail this completed form to Burbank Kids Dental at your earliest convenience. Thank you!

Physician's Name: ____________________ Physician's Phone #: ____________________

Physician's Fax #: ____________________ Physician's Office Name: ____________________

Physician's E-mail: ____________________ Physician's Signature: ____________________

I hereby authorize my Physician to release any pertinent facts regarding my child's medical history to Burbank Kids Dental.

Parent's Name: ____________________ Relationship to child: ____________________

Parent's Signature: _________________