



Macarena Planken DDS  
& Associates  
we love to see you smile

Dental Patient Information:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dear Doctor:

Our mutual patient (listed above) is scheduled for dental treatment.

The medical history completed by this patient indicates a history of:

\_\_\_\_\_  
\_\_\_\_\_

Please evaluate this patient's medical history and advise us to any special considerations that should be made for this patient with regard to the dental treatment.

Does the above mention patient need to be pre-medicated prior to dental treatment? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, specify preferred medication and regimen:

\_\_\_\_\_

Can local anesthetic be used on this patient?

\_\_\_\_\_ NO \_\_\_\_\_ Yes

If yes, can local anesthetic with epinephrine be used?

\_\_\_\_\_ NO \_\_\_\_\_ Yes

Additional comments or recommendations:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Physician Phone Number

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Physician Signature:

\_\_\_\_\_  
Physician's NPI Number

Please Fax Completed Form back to (516) 679-0855. Reach us at (516) 679-9444.