SUNRISE
Pediatric Dentistry

MEDICAL RELEASE FOR DENTAL TREATMENT

Patient's Name:	Patient's DOB	Today's 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 Sunrise Pediatric Dentistry 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 Dr. Elizabeth Crespi of Sunrise Pediatric Dentistry.

Parent's Name:

Relationship to child

Parent's Signature:

Sincerely,

Elizabeth Crespi, D.M.D.
Board Certified Pediatric Dentist

Sunrise Pediatric Dentistry
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