UNIVERSITY OF MARYLAND
SCHOOL OF DENTISTRY
REQUEST FOR MEDICAL/CONSULTATION FORM

Densyst #: _____

Patient's Full Name: _____

DOB: _____ Sex: _____ Date: _____

Address: _____

_____

The above is a patient at the University of Maryland School of Dentistry.
Dental Diagnosis: _____
_____

_____

_____

Recommended Dental Treatment: _____

_____

_____

_____

A medical/dental consultation is indicated in view of the following findings in the history and/or physical examination. _____

_____

_____

_____

_____

Please evaluate this patient and report your findings on the reverse side, including any contraindications or recommendations for proceeding with dental treatment. This form may be returned by the patient or by mail or fax.
I authorize the release of medical information as requested above:

Patient's/Parent's Signature: _____ Date: _____

DDS Signature: _____ Date: _____

Student Signature: _____ Date: _____

Return to: _____ **Room/Box #: _____**
University of Maryland Dental School **Phone/Fax: _____**
650 West Baltimore Street **or 410-706-8127**
Baltimore MD 21201-1586

Past Medical History:

Present Medical Status:

Present Medications & Dosages; Allergies:

Other Pertinent History:

Remarks: Please include results of pertinent laboratory test, vital signs, etc., as indicated. May this patient receive routine dental treatment? Are there any contraindications? Is any premedication indicated?

Thank you,

Signed: _____ M.D. Date: _____
D.D.S.

Address: _____

_____

Telephone: _____