

Gary A. Olen, D.D.S., M.S.
Michael J. Maurer, D.D.S.
Pediatric and Adolescent Dentistry
773 Broadway
El Cajon, Ca. 92021
Phone: 619-440-5915
Fax: 619-440-0605

MEDICAL RELEASE FORM

IN OUR CONTINUING EFFORTS TO ENSURE THE SAFETY OF OUR MUTUAL PATIENT, WE REQUEST YOUR RESPONSE TO OUR MEDICAL RELEASE FORM. PLEASE PROVIDE US WITH THE INFORMATION AND ANY SUGGESTIONS OR COMMENTS YOU MAY HAVE. IF YOU WOULD LIKE TO DISCUSS ANY PARTICULAR ASPECT OF THE PLANNED TREATMENT, PLEASE CALL OUR OFFICE AT (619) 440-5915 or FAX (619) 440-0605.

Dentist: Gary A. Olen, D.D.S., M.S. and Michael J. Maurer, D.D.S.

Patient Name: _____

Dental Diagnosis: _____

Medical History Of Concern: _____

**Does patient's medical condition require any special precautions before dental treatment can be rendered? Yes _____ No _____

Comments: _____

**Does patient require prophylactic premedication with antibiotics? Yes _____ No _____
If yes, choice and dosage of drug _____.

**Can dental tx be administered to the patient without risk to patient's health?
Yes _____ NO _____

**Can the local anesthetics be administered?

- A. Lidocaine 2% w/epinephrine 1:100,000 Yes _____ No _____
- B. Citanest Forte 4% w/epinephrine 1:200,000 Yes _____ No _____
- C. Carbocaine 3% w/out epinephrine Yes _____ No _____
- D. Citanest Plain 4% w/out epinephrine Yes _____ No _____

**Can x-rays be taken? Yes _____ No _____

Is there anything else that we should know about patient's health that would be significant to dental tx?

Yes _____ No _____ If Yes, What? _____

Physician name _____ Phone # _____
Physician's Signature _____ Date _____