



**IMPLANT DENTISTRY & ORAL REHABILITATION
EAST BRUNSWICK ORAL IMPLANT CENTER**

Gary R. Dornfeld, D.D.S.

MEDICAL HISTORY VERIFICATION

PATIENT NAME _____ MUST BE RETURNED BY _____
ADDRESS _____

DEAR DOCTOR: THE ABOVE PATIENT IS SCHEDULED FOR IMPLANT ORAL SURGERY. PLEASE VERIFY AND/OR PROVIDE THE FOLLOWING MEDICAL INFORMATION, AND INDICATE ANY CONTRAINDICATIONS TO THE PROCEDURE OR MEDICATIONS WE WILL BE PRESCRIBING.

DATE OF MOST RECENT PHYSICAL _____
SIGNIFICANT MEDICAL OR PSYCHOLOGICAL PROBLEMS _____

RESULTS OF SMA-12/60 (OR COMPARABLE) NORMAL _____ ABNORMAL _____
COMMENTS _____

CBC NORMAL _____ ABNORMAL _____ COMMENTS _____

URINANALYSIS NORMAL _____ ABNORMAL _____
COMMENTS _____
(PLEASE ATTACH LABORATORY RESULTS)

MEDICATIONS TO BE PRESCRIBED:

ANTIBIOTIC _____
PAIN _____
SEDATION _____
ANTI-SWELLING _____
VITAMINS _____
OTHER _____

CONTRAINDICATIONS AND RECOMMENDED ALTERNATIVES _____

THE ABOVE PATIENT HAS AN ACCEPTABLE MEDICAL HISTORY FOR
OUTPATIENT ORAL IMPLANT SURGERY YES _____ NO _____

COMMENTS _____

SIGNATURE OF PHYSICIAN _____ DATE _____
(PLEASE ALSO PRINT OR STAMP NAME AND ADDRESS)

DIPLOMATE
A.B.O.I.

FELLOW
AMERICAN
ACADEMY IMPLANT
DENTISTRY

FELLOW
INTERNATIONAL
CONGRESS ORAL
IMPLANTOLOGY

DIPLOMATE
AMERICAN
SOCIETY OF
OSSEointegration

MEMBER
AMERICAN
DENTAL ASSOCIATION