MEDICAL CONSULTATION CONSENT FORM

Patient's Name _____ DOB _____

Address _____

From: **Menlo Park Dental Excellence / Dr. ChauLong Nguyen, D.D.S, MAGD, AAID**
905 Middlefield Rd, STE B, Palo Alto, CA94301 Phone: 650-838-0260 Fax: 818-928-6058

Dear Dr. _____,

The above patient informed my office that he/she is one of your patients. The dental treatment plan includes the following: routine teeth or scaling and root planning-deep cleaning- cleaning that may have bleeding from the gum, LASER gum surgery, fillings, crown, root canal therapy, tooth extraction, implant surgery, bone grafting with local anesthetic with epinephrine 1:100,000.

_____

Based upon your medical knowledge of the patient, do you recommend any modifications?

_____

_____

_____

❑ None

Is the patient currently being treated in your office? ❒ Yes ❒ No (If yes, for what condition(s)?)

_____

_____

_____

Signed _____, M.D. Date _____

_____

Permission to Release Information

I, _____ give permission to Dr. _____ to release to Dr. ChauLong Nguyen any information about my health status related to the above request.

Patient Signature _____ Date _____

Witness Signature _____