

Burris Cosmetic and Family Dentistry
199 South Street
Camden, De. 19934
302-697-3125

Date: _____

RE: Patient: _____ D.O.B. _____

The above patient has requested treatment at our office and indicates the following conditions (s):

Premedication: Does patient need antibiotic prophylaxis prior to dental treatment? _____ NO _____ YES (if so, what type?)

How long will patient be required to take this? _____

Answer "YES" or "NO" if patient can have:

___ Prophylaxis- (cleaning) ___ Local Anesthetic

___ Radiographs ___ Extractions

Other: _____

Physician's comments: _____

Physician's Signature: _____ **Date:** _____

Physician's name (print): _____

Treating Dentist Sent by