Consultation Form for Pregnant Women to Receive Oral Health Care

Referred to: _____ Date: _____

Patient Name: (Last)_____(First)_____

DOB: _____Estimated delivery date: _____Week of gestation today: _____

KNOWN ALLERGIES: _____

PRECAUTIONS: ❒ NONE ❒ SPECIFY (If any):

_____

_____

_____

This patient may have routine dental evaluation and care, including but not limited to:

- Oral health examination
- Dental prophylaxis
- Scaling and root planing
- Extraction
- Dental x-ray with abdominal and neck lead shield
- Local anesthetic with epinephrine
- Root canal
- Restorations (amalgam or composite) filling cavities

Patient may have: (Check all that apply)

❒ Acetaminophen with codeine for pain control
❒ Alternative pain control medication: (Specify) _____
❒ Penicillin
❒ Amoxicillin
❒ Clindamycin
❒ Cephalosporins
❒ Erythromycin (Not estolate form)

Prenatal Care Provider: _____ Phone: _____

Signature: _____Date: _____

DO NOT HESITATE TO CALL FOR QUESTIONS

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DENTIST'S REPORT
(for the Prenatal Care Provider)

Diagnosis: _____

_____

Treatment Plan: _____

_____

_____

NAME: _____ Date: _____ Phone: _____

Signature of Dentist:_____