Please Fax to:
(940) 613-0213

Must be completed by Physician
2 Weeks prior to Surgery Date
WITHIN 30 DAYS OF SURGERY DATE
Not Before: _____
Need By: _____

PRE-SURGERY PHYSICAL

NAME: _____DOB:_____/_____/_____SS#_____

Scheduled Admission Date: _____Date of Examination: _____

Allergies: _____

Medications: _____

CC: _____

HPI: _____

PH: _____

BP_____TEMP_____RESP._____PULSE_____WT._____HT._____

HEENT: _____

_____

RESPIRATORY: _____

_____

CARDIOVASCULAR: _____

_____

PROVISIONAL DIAGNOSIS: Multiple Dental Caries

PHYSICIAN INSTRUCTIONS TO PATIENTS: _____

_____

FOLLOW-UP PLAN: Dr. Timothy Lee,DDS

FINAL DIAGNOSIS: Multiple Dental Caries

PROCEDURES: Full Mouth Dental Rehab

_____

Physician's Signature Date Time

_____

Print Signature