Gary A. Olen, D.D.S, M.S., Inc.
Michael Maurer, D.D.S, M.S., Inc.
773 Broadway
El Cajon, Ca. 92021
Phone: 619-440-5915
Fax: 619-440-0605

MEDICAL RELEASE FORM

IN OUR CONTINUING EFFORTS TO ENSURE THE SAFETY OF OUR MUTUAL PATIENT, WE REQUEST YOUR RESPONSE TO OUR MEDICAL RELEASE FORM. PLEASE PROVIDE US WITH THE INFORMATION AND ANY SUGGESTIONS OR COMMENTS YOU MAY HAVE. IF YOU WOULD LIKE TO DISCUSS ANY PARTICULAR ASPECT OF THE PLANNED TREATMENT, PLEASE CALL OUR OFFICE AT **(619) 440-5915** or **FAX (619) 440-0605.**

Dentist: Gary A. Olen, D.D.S., M.S. Inc. & Michael Maurer, D.D.S., M.S., Inc.

Patient Name: _____

Dental Diagnosis: _____

Medical History of Concern: _____

**Does patient's medical condition require any special precautions before dental treatment can be rendered? Yes _____No_____
Comments:
_____
_____

**Does patient require prophylactic premedication with antibiotics? Yes____ No_____ If yes, choice and dosage of drug_____.

**Can dental treatment be administered to the patient without risk to patient's health? Yes___ No___

**Can the local anesthetics be administered?

A. Lidocaine 2% w/epinephrine 1:100,000 Yes____ No____
B. Citanest Forte 4% w/epinephrine 1:200,000 Yes ____ No____
C. Carbocaine 3% w/out epinephrine Yes ____ No____
D. Citanest Plain 4% w/out epinephrine Yes ____ No____

**Can x-rays be taken? Yes___ No_____
Is there anything else that we should know about patient's health that would be significant to dental tx?
Yes_____ No_____ If Yes, What? _____

Physician name_____ Phone #_____
Physician's Signature_____ Date_____