Sleep Dentistry℠ of PORTLAND LLC
A Dream away from your perfect smile!

Floyd H. Kasch, D.M.D.
Cosmetic & General Dentistry for the Entire Family

Date: _____

To Dr._____ Phone_____ Fax_____

Our mutual patient_____ DOB: _____ has noted the following condition(s) in a routine health history:

☐Heart Murmur/MVP ☐ High Blood Pressure; Today's reading_____
☐Bleeding Disorders/Taking Blood Thinners ☐Major surgery _____
☐Other_____

A dental examination of this patient has revealed the need for:
_____.

Please answer the following questions below pertaining to this patient and return to our office, so we may better serve the patient.

1) Is this patient stable enough for treatment in a clinical setting?
   ☐YES ☐NO_____
2) Does the patient require Prophylactic Antibiotic prior to treatment?
   ☐ YES ☐NO
   Oral regimen recommended: _____
3) Are there any contraindications to the use of:
   Local Anesthesia ☐YES ☐NO
   Local w/vasoconstrictor ☐YES ☐ NO
   Conscious IV Sedation ☐YES ☐ NO
   Conscious Oral Sedation ☐YES ☐NO
4) Are there any medications that need to be altered prior to dental treatment?
   ☐ NO ☐YES _____

_____ _____ _____
Physician's Signature Printed Name Date

Patient Authorization

I herby give my authorization to use or disclose my protected health information to Sleep Dentistry L.L.C. I authorize my dentist to receive and use my information for the purpose of documenting any and all medical clearance required prior to dental treatment. I agree with all statements made in this release. I understand that by signing this form I am consenting to use and disclosure of the protected health information described in this form with the office named herein.

_____
Signature Printed Name Date