

Fax Transmission
Physician's Immediate Reply Requested
CONFIDENTIAL

Date: _____

Pages: _____

To: _____

Fax: _____

Physician's Name

Physician's Fax Number

From: Forrest R. Boozer D.D.S.

Phone: (530) 676-9999

Re: _____

Fax (530) 672-1473

Patient's Name

Dentist Fax Number

Patient's Signature authorizing exchange of information between dentist and physician

_____ Patient's date of birth

1. Dental Treatment Plan:

2. Patient's Condition that may warrant special considerations:

3. If prophylactic antibiotic treatment is required, I will follow current AHA guidelines and prescribe the following protocol and prescription:

To be completed by the Physician

1. Is the patient healthy enough to undergo this treatment?

Please initial: Yes _____ No _____

2. Does the patient's medical condition require prophylactic antibiotic treatment?

Please initial: Yes _____ No _____

3. If you recommend a different prophylactic treatment plan or antibiotic, please

Indicate: _____

Dentist's Signature: _____ Date _____

Physician's Signature: _____ Date _____