

Rx

Bring this with you to your next appointment!

Patient Name: _____

Date of Birth: _____ Estimated Delivery Date: _____

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

- | | |
|---|---|
| <input type="checkbox"/> Oral health examination | <input type="checkbox"/> Local anesthetic with or without epinephrine |
| <input type="checkbox"/> Dental prophylaxis | <input type="checkbox"/> Root canal treatment |
| <input type="checkbox"/> Dental x-ray with neck and abdominal lead shield | <input type="checkbox"/> Extraction |
| <input type="checkbox"/> Restoration (amalgam or fillings) | <input type="checkbox"/> Scaling and root planning (deep cleaning) |

Known Allergies: _____

Precautions: None Specify (if any) _____

Patients may be prescribed the following pain medication(s)

- Acetaminophen with codeine
 Alternative medication (specify): _____

Patient may be prescribed the following antibiotics:

- Penicillin Amoxicillin Clindamycin
 Cephalosporins Erythromycin (not estolate form)
 No Antibiotics Other _____

Signature: _____ Date: _____

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