Alternative Dental Care

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Medical Order Request for Dental Hygiene Treatment

DENTIST/MEDICAL PROVIDER: _____

PATIENT'S NAME: _____

RESIDING AT:_____

BECAUSE OF THE PATIENT'S DISABILITY AND/OR INABILITY TO TRAVEL AND BE TREATED IN A DENTAL OFFICE, THE PATIENT MAY HAVE ORAL HYGIENE SERVICES PERFORMED BY SUSAN DRAGOO, RDHAP, ALTERNATIVE CARE DENTAL HYGIENE PRACTICE, AND ASSOCIATES, INCLUDING ORAL SCREENING, ORAL PROPHYLAXIS, PERIODONTAL SCREENING, NON-SURGICAL PERIODONTAL THERAPY, ORAL CARE PLAN, AND ANY OF THE FOLLOWING: CHLORHEXIDINE GLUCONATE PRN, LIP BALM PRN, FLUORIDE TREATMENT PRN, ORAQIX TPICAL (2% LIDOCAINE/2% PRILOCAINE) PRN, 20% BENZOCAINE TOPICAL PRN.

DOES THIS PATIENT HAVE ANY MEDICAL CONCERNS THAT WOULD REQUIRE ENDOCARDITIS PROPHYLAXIS? _____

IF SO, PLEASE LIST PATIEN'TS MEDICAL CONDITION: _____

_____

KNOWN ALLERGIES:_____

PHYSICIAN/DENTIST LICENSE NUMBER: _____

DEA NUMBER:_____

PHYSICIAN/DENTIST SIGNATURE: _____