Prenatal medical-to-dental referral form

Patient Information

Patient Name:		DOB:	/	/
Telephone:		Est. Delivery Date: / /		
Medical Professional Informatio	n			
Primary/Prenatal Care Professional:		Date:	/	/
Telephone:	Fax:			
Signature:				
Re	ferral Information	n ——		
Reason for Referral: ☐ Routine ☐ Gingivitis ☐ Dental Caries ☐ Pain ☐ Other				
☐ This patient is cleared for	r routine dental evaluation a	nd care		
Known Allergies:				
Medications Patient is Currently Taking:				
Significant Medical Conditions: ☐ None ☐ Ye				
Routine dental evaluation and care is safe during pregnancy, including (but not limited to):	Medicat	ions that are safe	e to use du	ring pregnancy:
 Oral health examination Dental x-ray with abdominal and neck lead shield Dental prophylaxis Local anesthetic with epinephrine Periodontal the Restoration (am composite fillin Root canal treat Extraction 	nalgam or without egs) • Amoxic	osporins	Erythroform)Penicill	omycin (not estolate in

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Dental Professional Name:



For help finding a dental professional, call your insurance company or 2-1-1.

Telephone: