REQUEST FOR IMFORMATION

To Dr. _____ Date _____

Patients Name_____ D.O.B : _____

Presented in our office on _____ for a new patient examination. Upon updating his/ her health history reported _____

Since we do not want to cause any harm to this patient's medical status, could you please confirm that anitibiotics **are or are not** required for dental procedures and return this form to us at your earliest convenience.

Thank you for your assistance in this important matter.

_____
Dr. Aram Mohajer D.D.S

MEDICAL DOCTOR'S RESPONSE

ANTIBIOTIC COVERAGE REQUIRED ☐ for the above named patient.
PATIENT'S CONDITION: _____
ANTIBIOTIC COVERAGE NOT REQUIRED ☐ for the above named patient.

_____ _____
Doctor's signature Date

PRINT

A R I . D E N T A L
46 J O H N S T R E E T
TORONTO, ON , M5V-3W2
T. 4 1 6 9 7 7 1 4 1 4
F. 4 1 6 6 4 5 3 3 4 3
S T A F F @ A R I . D E N T A L

A R I . D E N T A L
451 KING STREET WEST
TORONTO, ON, M5V-1K4
T. 4 1 6 6 4 5 3 3 4 4
F. 4 1 6 6 4 5 3 3 4 3
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