half moon
dentistry for children

Dr. N. Vertel Inc.
DDS
Certified Specialist in Pediatric Dentistry

110 - 15252 32 Avenue Surrey BC V3Z 0R7
T 604 536 7697 F 604 385 0015 E
info@halfmoondentistry.com
halfmoondentistry.com

(Please complete and fax to **604 385 0015)**

Dear Doctor,
Your patient is scheduled for dental treatment general anesthesia. Please complete this history and physical examination form, and return it to our office. If you have any questions, please contact our office. Thank you for your assistance.

Patient's Name _____

Date of Birth _____ Phone _____

Address_____

City/Province _____ Postal Code _____

Planned Dental Treatment: Dental restoration and/or extractions under general anesthesia

ALLERGIES_____

MEDICATION_____

FUNCTIONAL INQUIRY

☐Cardiac_____

☐Respiratory_____

☐Other_____

PAST ILLNESS

☐ Anesthesia Experience_____

☐Other_____

FAMILY HISTORY

☐ Anesthesia Problems_____

☐Other_____

PHYSICAL EXAMINATION

☐ General Appearance_____

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☐ B/P _____ P. _____ R. _____ Wt. _____ Ht. _____

☐ Head, Neck and Intraoral_____

☐Heart_____

☐Lungs_____

☐Abdomen_____

☐Skeletal_____

☐CNS_____

Laboratory Tests_____

ASA CLASSIFICATION I II III IV

Date _____

Physician's Signature: _____