half moon
dentistry for children
halfmoondentistry.com T 604 536 7697
info@halfmoondentistry.com F 604 385 0015

Dr. Nancy Vertel- Owner
Certified Specialist Restricted to Pediatric Dentistry

Dr. Christina Chan - Associate
Certified Specialist in Pediatric Dentistry
Associate

(Please fill out and fax back to 1-888-607-7153)

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_____
- 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 _____