WARREN ORAL SURGERY

COMPASSIONATE CARE

Surgical Medical Clearance Required

Please provide your physician's information so we can obtain a medical clearance prior to your date of surgery.

Physician Name: _____ Specialty: _____

Phone Number: _____ Fax Number: _____

City: _____ State: _____

Physician Name: _____ Specialty: _____

Phone Number: _____ Fax Number: _____

City: _____ State: _____

58 Mt Bethel Road, Suite 202, Warren, New Jersey 07059
Tel 908-222-7922, Fax 908-222-7923
Email: frontdesk@warrenoralsurgery.com
www.warrenoralsurgery.com

WARREN ORAL SURGERY

COMPASSIONATE CARE

Pre-op Evaluation

This patient is scheduled for Oral Surgery in the near future. Please fax or email this form with any relevant supporting documentation to Warren Oral Surgery. Your assistance is greatly appreciated.

Patient's Name_____ Birth date____/____/_____
Patient's Phone (HOME) _____ (MOBILE)_____
Treating Surgeon _____ Diagnosis _____
Pre-op Date____/____/____ Surgery Date____/____/____Anesthesia_____
Proposed Surgery_____

Significant past medical history: _____

List of previous operations: _____

Current medication with dosages:

Drug and Food Allergies:

B/P:_____ Pulse: _____

HEENT_____

LUNGS_____

CARD/VASC_____

ABD_____

EXT_____

NEURO/PSYCH_____

DIAGNOSIS_____

Perioperative Recommendations:_____

Is this patient cleared to have surgery? _____

Date: ____/____/____Print name: _____ Signature_____

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