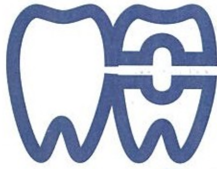

Laxer, Long & Savage
Specialists In Pediatric Dentistry & Orthodontics

Judy S. Laxer, DDS, Cert. Pedo.
Sonny Long, DDS, MS
Matthew F. Savage, DDS, MS

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Charlotte, North Carolina 28277
704-759-0000 • Fax 704-759-9937
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Date____________

Because ____ requires sedation medication to successfully administer dental treatment, I am requesting that you perform a health evaluation within 6 months of oral sedation with Versed/Midazolam (________________________________). Please complete this form and feel free to contact me with any questions. Please fax to our office.

Thank you in advance,

Judy S. Laxer, D.D.S., Cert.Pedo.
Matthew F. Savage, D.D.S., M.S.

Chief Complaint: dental caries

Present Illness:____

Past Medical History:

_______ **None significant, including no history of drug reaction, sensitivity, allergy, asthma, hayfever, egg allergy**
_______ **Significant PMH:**____

_______**ASA rating**____

Previous Operations:

_______ **None**
_______ **Dates & Type:**____

Family History:

_______ **No significant history of familial disease.**
_______ **Significant FH:**____

Review of Systems:

_______ **No further contributory.**
_______ **Significant ROS:**____

Physical Examination:

Vital Signs: BP_____/_____ **P**_____ **R**_____ **T**_____ **WT**_____

HEENT	_____**WNL**	**Neck**	_____**WNL**
Chest	_____**WNL**	**Heart**	_____**WNL**
Breasts	_____**WNL**	**Abdomen**	_____**WNL**
Genitalia	_____**WNL**	**Extremities**	_____**WNL**
Rectal	_____**WNL**	**Neurological**	_____**WNL**

Airway Assesment:____

Impressions and Recommendations:__________________________________

___________ ______________________________ ________________
Date *Signature of Physician* *Office Phone Number*