

**CARING DENTISTRY  
P. O. BOX 1502  
ASHLAND, KY 41105  
TEL. 606-324-3552 / FAX. 606-324-2092**

**PHYSICIAN'S HISTORY, PHYSICAL ORDER AND PROCEDURE**

**PATIENT NAME:** \_\_\_\_\_

**PRESENT ILLNESS:** \_\_\_\_\_

**PAST MEDICAL HISTORY:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**PHYSICAL EXAM:**

	<b>NORMAL</b>	<b>ABNORMAL</b>
<b>SYSTEM</b>	_____	_____
<b>LUNGS</b>	_____	_____
<b>ABDOMEN</b>	_____	_____
<b>EXTREMITIES</b>	_____	_____
<b>HEAD</b>	_____	_____
<b>EENT</b>	_____	_____
<b>HEART</b>	_____	_____

**ABNORMAL FINDINGS ON EXAM:**  
\_\_\_\_\_  
\_\_\_\_\_

**DATE OF H&P:** \_\_\_/\_\_\_/\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_

**\*\*FOR PATIENTS IN NURSING HOMES OR LONG CARE FACILITIES PLEASE HAVE LABS PERFORMED AND FAXED TO THE DENTAL OFFICE APPROXIMATELY 2-3 DAYS PRIOR TO DENTAL SURGERY\*\***

**\*\*FOR ALL OTHER PATIENTS IT WILL BE LEFT UP TO THE DISCRETION OF THE FAMILY PHYSICIAN WHETHER OR NOT LABS WILL NEED TO BE DRAWN IN ORDER TO RELEASE PATIENT FOR DENTAL SURGERY\*\***