



6820 Parkdale Place, Suite 117

Indianapolis, IN 46254
Phone: 317-329-7373
Fax: 317-735-2161

Patient Medical Consultation Request

Doctor

Patient

Address

DOB

Dear Doctor, our patient has listed you as their primary care physician. This patient has extensive dental and oral health needs. We have recommended treatment to be completed using general anesthesia. Our Dental Anesthesiologist has requested the following evaluations and test to ensure the safety of this patient under general anesthesia.

Signed By: _____

Date: _____

Physician Response & Advisories:

Below is parent/guardian release of information

Permission is granted for the release of information concerning my health or my above named dependent's health to Eagle Creek Children's Dentistry.

Patient/Parent/Guardian: _____

Date: _____

Please return fax to Eagle Creek Children's Dentistry
6820 Parkdale Place Suite 117
Indianapolis, IN 46254
Fax: 317-735-2161
e-mail: spvdds@me.com , msaxen@mw.net
with results, evaluations of these test.

Thank you for your cooperation.