Geshay Pediatric Dentistry, P.C.
James B. Geshay Jr., D.D.S.
634 Pittsburgh Road
Uniontown, PA 15401
(724)439-1576

MEDICAL PHYSICAL

Please have form completed and faxed to our office at least two weeks prior to appointment.
FAX (724) 438-7007

Re: _____ DOB: _____ Date: _____

Dear Doctor:

The above mentioned patient is scheduled to have all dental treatment completed in the dental office under Oral Conscious Sedation. This technique utilizes Chloral Hydrate, Vistaril, Demerol, and Nitrous Oxide.

In order to obtain updated information for our anesthesia records, we would like for you to send us a report on the patient's present health status.

Please provide the information requested below:

1. **Patient's present weight:** _____ lbs (please specify with or without clothing)
   height: _____
2. **Patient's resting:** Blood Pressure _____
   Respirations _____ /min
3. **Non-Dental Problems:** _____
4. **Intellectual & Emotional (i.e. Downs' Syndrome, Autism, Combative, ADHD, etc):**
   _____
5. **Any History of:**
   _____ Allergy to Medication
   _____ Bleeding Problems
   _____ Problems with General Anesthesia / Oral Sedation
   _____ Croup
   _____ Seizures
6. **Physical Problems:**
   _____ Enlarged Tonsils and Adenoids
   _____ Obesity
7. **Chronic Disease:**
   _____ Diabetes
   _____ Asthma or Breathing Related Problems
   _____ Heart Disease or Murmur
   _____ Lung, Kidney, Liver, Blood Disorders, etc.
8. **Present Medications:** _____
9. **Contraindications:** _____
10. **Date of Physical:** _____ **Date Form Completed:** _____

Doctor's Initials: _____ Doctor's Name: _____

Thank you for your effort and consideration. Street Address: _____

Cordially,
James B. Geshay Jr. D.D.S. Phone Number: _____

~OCS~

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Uniontown, PA 15401
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MEDICAL PHYSICAL

Please have form completed and faxed to our office at least two weeks prior to appointment.
FAX (724) 438-7007

Re: _____ DOB: _____ Date: _____

Dear Doctor:

The above mentioned patient is scheduled to have all dental treatment completed in the dental office under IV Sedation, administered by a Dental Anesthesiologist.

In order to obtain updated information for our anesthesia records, we would like for you to send us a report on the patient's present health status.

Please provide the information requested below:

1. **Patient's present weight:** _____ lbs (please specify with or without clothing)
   height: _____
2. **Patient's resting:** Blood Pressure _____
   Respirations _____ /min
3. **Non-Dental Problems:** _____
4. **Intellectual & Emotional (i.e. Downs' Syndrome, Autism, Combative, ADHD, etc):**
   _____
5. **Any History of:**
   _____ Allergy to Medication
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