We Keep Families Smiling

CORNING DENTAL ASSOCIATES RLLP

Patient Name: Date:

Orthopedic Surgeon/Office: Date of Surgery: Type:

To help facilitate the best quality treatment for our patients and to ensure good communication please fill out the following form and return to our office. Thank you.

This patient will require antibiotic prophylactic pre-medication for the following time period following surgery:

6 MOS: _____ 2 YRS: _____ FOR LIFE: _____ Other: _____

Antibiotic **YOU** will be prescribing for patient:

Amoxicillin 2g- 1 hr before appt:_____

Clindamycin- 600mg -1hr before appt: _____

Cephalexin-2g-1hr before appt: _____

Other: _____

Procedures requiring pre-medication:

Dental Cleaning that may involve bleeding: _____

Tooth extractions/ invasive dental surgery: _____

Fillings that may involve bleeding: _____

Other: _____

Completed By Name: Position:

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