



REQUEST FOR DENTAL SCREENING
PLEASE COMPLETE ENTIRE FORM
AND PRINT CLEARLY

DATE: _____ FAXED BY: _____

FACILITY: _____ ROOM: _____

NAME OF PATIENT: _____ D.O.B: _____

INITIAL SCREENING: () EMERGENCY CARE:() NATURAL TEETH: () DENTURES: ()

REASON FOR REQUEST: _____

ADDITIONAL INFORMATION (pain, swelling, broken denture, ect): _____

MEDICAL HISTORY:

Blood thinners Y N if yes, list _____

Drug allergies Y N if yes, list _____

Pacemaker Y N

Heart condition Y N

Heart murmur Y N

Hip replacement Y N

Any reason to premedicate with antibiotics/sedative? Y N

PHYSICIAN'S NAME AND PHONE NUMBER: _____

Is patient covered by:

- INSURANCE Y N
- ODSP Y N
- DVA Y N K# _____

Is NOK the financially responsible party? Y N If no, who is financially responsible?

NAME: _____

ADDRESS: _____
STREET NAME CITY PROVINCE POSTAL CODE

PHONE: (H) _____ (B) _____

EMAIL: _____

I/we authorize Golden Care Dental Services to complete an initial assessment for this resident. I/we consent to the release of all necessary contact information to Golden Care Dental Services to facilitate direct communication regarding dental care.

SIGNATURE: _____ (PRINT NAME) _____