Paul D Biederman, DDS
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410.740.0606 410.465.6000
410-964-3630 (Fax)

KIDS DENTAL CENTER LLC

To Primary Care Physician:

Please complete a physical exam on this patient to determine if he / she may undergo outpatient dental treatment utilizing general anesthesia. **The exam needs to be completed within 30 days of the scheduled dental treatment. Please complete the attached pre-operative physical exam form and fax through to the hospital.**

Thank You.

Daniel Biederman, DDS
Kids Dental Center, LLC

Please complete the History & Physical form and FAX to (410) 884-4842

Howard County General Hospital, Inc	5759 Cedar Lane
The Center for Ambulatory Surgery	Columbia, MD 21044
(410)884-4842 Fax	(410)884-4501

History and Physical

Patient (last, first): Sex: DOB: Address: Appointment: _____ Location: Howard County General Hospital—Outpatient /Ambulatory Center
Chief Diagnosis: Dental Caries 521.00
Indications for Surgery: Age, behavior, medical necessity, pre-cognitive development
Surgical Plan of Care: Dental Restorative / Dental Extraction

Ht:_____Wt:_____Temp:_____BP:_____P:_____R:_____

Past History	**Negative**	**Positive**	**If Positive, Specify**
Operations	☐	☐	
Transfusions	☐	☐	
Injuries	☐	☐	
Illness	☐	☐	
Allergies	☐	☐	
Family History / Illness	☐	☐	
Smoker	☐	☐	
Alcohol Consumption	☐	☐	
Medications	☐	☐	
Review of Systems	**Negative**	**Positive**	**If Positive, Specify**
Cardiovascular	☐	☐	
Respiratory	☐	☐	
Central Nervous	☐	☐	
Genitourinary	☐	☐	
Musculoskeletal	☐	☐	
Hematologic	☐	☐	
Lymphatic	☐	☐	
HEENT	☐	☐	
Breast	☐	☐	
Abdominal	☐	☐	
Pelvic	☐	☐	
Rectal	☐	☐	

My signature indicates that in my opinion, this patient is healthy enough to undergo general anesthesia in an outpatient hospital setting in order to treat dental pathology.

MD Signature:_____ Date:_____

PLEASE FAX THIS FORM TO (410) 884-4842