Sample Form: Patient Contact After-hours

Date and time of call:____________________ Caller's name:____________________

Patient name (if other than caller):____________________

Home phone:______________ Work phone:______________ Cell phone:______________

What is your complaint?____________________

When was your last dental visit?____________________

Are you currently under the care of a physician?____________________

Since when, and for what reason?____________________

Have you had any recent non-dental physical/health problems?____________________

What medications are you now taking (prescription, over-the-counter, and supplements)?____________________

____

To the best of your knowledge, do you have any drug allergies or toxic reactions to medications?

____

Medical History Review:

heart disease/rheumatic fever/murmur/prosthesis; bleeding disorders/anemia; BP high or low; TB; asthma or respiratory disease; prosthetic joints; diabetes/endocrine system; kidneys; hepatitis; ulcers/GI; history of malignancy; chemo or radiation therapy; seizure disorders; pregnancy; alcohol use and abuse; venereal disease; HIV/immunosuppression

Do you have or have you suffered from any other disease or condition?____________________

____

Differential diagnoses:____________________

Advice given to patient:____________________

Drugs prescribed (name, quantity, dosage, instructions, refills):____________________

____

Drug information given or prescription:____________________

Name of pharmacy:____________________ Pharmacy telephone number:____________________

Date set for examination of patient:____________________

Warning symptoms requiring immediate attention:____________________

Was patient informed of risks and limitations of palliative treatment? ☐ Yes ☐ No

Is patient aware of the need to come to the office for examination as soon as possible? (If applicable) ☐ Yes ☐ No

Is patient aware of the need to seek emergency treatment if his or her condition worsens or he or she experiences an unusual reaction to medications prescribed? ☐ Yes ☐ No

This sample form is for illustrative purposes only. Your form's content and layout may be different. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice. Published by CNA and provided through the Dentist's Advantage insurance program and the National Society of Dental Practitioners. Copyright © 2019 CNA. All rights reserved. Published 5/19.