Evaluation of the Dental Implant Patient Form

NEW YORK STATE DEPARTMENT OF HEALTH

Bureau of Dental Review

Dentist Name:_____ NPI:_____

Member Name:_____ CIN:_____ Age:_____

Medical History:_____

_____

_____.

Current Medications:_____

_____

_____.

Allergies to Medications:_____.

List any significant medical conditions that the member is currently being treated for: _____

_____.

Identify the physician(s) currently treating the member for any of the above-listed medical condition(s):

_____.

Detail the member's medical necessity for dental implants: _____

_____.

Detail why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition:

_____

_____.

The above patient is an acceptable candidate for dental implant surgery: _____Yes _____No

_____

Dentist signature:_____Date:_____