JENNIFER A SOKOLOSKY DMD, PA

6100 DAY LONG LANE, STE 105
CLARKSVILLE, MD 21029
410.531.2690

Patient Name: _____ DOB: _____

Dear _____,

The above named person is a patient at our dental office. We need to consult with you regarding the following matter(s). Please review the checked areas below, write your recommendations, and return to our office as soon as possible to prevent delays in treatment. Thank you so much for your time and attention.

_____ Does this patient require subacute bacterial endocarditis prophylaxis?

_____ Yes _____ No

Please fax this completed form to:

_____	_____	_____
Physician name	Physician Signature	Date

_____	_____	_____
Dentist Name	Dentist Signature	Date