DENTAL REFERRAL FORM FOR PREGNANT WOMEN

Patient Referred to: _____ Referred Date: _____
(Dentist Name | Practice)

Patient Information

Name: _____ _____ Date of Birth: _____
(Last) *(First)* Estimated Delivery Date: _____

Known Allergies and Precautions: *(Specify, if any)*

The following are considered safe during pregnancy:

Dental Procedures:
- Oral Examination
- Dental Prophylaxis
- Scaling and Root Planing
- Extraction
- Dental X-ray with Lead Shielding
- Local Anesthetic with Epinephrine
- Root Canal
- Restorations | Fillings

Medications:
- Amoxicillin
- Cephalosporins
- Clindamycin
- Metronidazole
- Penicillin
- Acetaminophen
- Acetaminophen with Codeine, Hydrocodone, or Oxycodone

Patient may NOT have: *(Specify)*

Referring Prenatal Provider

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Name: _____ Signature: _____
(Please Print)

Date: _____ Contact: (___) ___-_____ Provided by: MARYLAND Department of Health