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:______________________________