

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: _____