ROGERS PROSTHODONTICS

RE: NEED FOR ANTIBIOTIC COVERAGE FOR DENTAL WORK
PLEASE ADVISE
DATE OF REQUEST_____

Our mutual patient: _____DOB: _____
Has an upcoming dental appointment. If antibiotic coverage is necessary or is not required, please advise.

If Antibiotic coverage is required, please provide the specific antibiotic, dosage, and instructions; length of time required (i.e., 2 years or lifetime or…?):

_____

_____

Antibiotic Coverage is required as described above: _____
(Doctor's signature and date)

If coverage is required, please prescribe for the initial visit, thank you.

Antibiotic coverage is not required: _____
(Doctor's signature and date)

Thank you for your consideration in keeping our patients safe.

H. Winslow Rogers III, D.D.S., M.S.
Diplomate of the American Board of Prosthodontists
400 Peachtree Street Rocky Mount, NC 27804
Office: 252-446-0117, Fax: 252-446-2264
rogersprosthodontics.com