Idaho Oral & Maxillofacial Surgery, PC
Timothy T. Hopkins, DDS,MS

MCNA Patient Evaluation

Name:________________________________ Birth date: _______________

MCNA ID# __________________

Do you have pain? none occasional continuous

If yes, what tooth # or area ___________________________________

Do you have swelling? Y N

If yes, what area ____

Is your mouth limited to opening? Y N

Have you been hospitalized recently for dental pain? Y N

If so when ____

Have you been treated for any of the above symptoms by your dentist? Y N

If yes, were you given antibiotics or pain medication for dental pain? Y N

List any other additional information you think might be helpful for MCNA to determine medical necessity for services ____________________________
____
____

Signature __________________________ Date ________________________

PLEASE CALL OUR OFFICE TO CHECK STATUS OF AUTHORIZATION IN ABOUT 4 WEEKS 208-733-1182. WE WILL NOT CONTACT YOU.