MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date: _____ Attention: _____

Patient Name: _____ Date of Birth: _____

Our mutual patient, as noted above, is scheduled for dental treatment at our office. Treatment may include:

- ☐ Cleaning (simple or deep)
- ☐ Radiographs (x-rays)
- ☐ Fillings, Crowns, Bridges
- ☐ Extraction (simple or surgical)
- ☐ Root Canal Therapy
- ☐ Nitrous Oxide
- ☐ Local Anesthetic (with Epinephrine)
- ☐ Other: _____

The patient has indicated the following medical conditions:

_____

_____

Dentist Comments:

_____

_____

Dentist Name (Please Print) _____ Dentist Signature _____ Date _____

Physicians: Please complete the section below.

Evaluate this patient's medical history and advise us of any special considerations that should be made.

Does the patient require antibiotic prophylaxis? ☐ Yes ☐ No

Reason for prophylaxis: _____

Does the patient require an interruption of anticoagulant treatment? ☐ Yes ☐ No

How long before and after treatment? _____

Are there any restrictions anesthetic for this patient? ☐ Yes ☐ No

Is the use of epinephrine okay? ☐ Yes ☐ No

Type of antibiotic that is allowed/recommended for patient: _____

Type of pain medication that is allowed/recommended for patient: _____

Additional comments:

_____

_____

Physician Name (Please Print) _____ Physician Signature _____ Date _____

We appreciate your assistance in providing optimum care for this patient.
Please have the physician sign and fax this form to the office selected below: