MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date: ____________________

Patient: ____ Date of Birth: ______________________________

Dear Dr. ______________________________

Our mutual patient, ____ is scheduled for dental treatment.

Treatment may include:

- Cleanings (Simple or deep)	- Radiographs	- Nitrous Oxide
- Fillings, Crowns, Bridges	- Root Canal Therapy	- Extraction
- Local Anesthetic (with epinephrine)	- Other: ____	

The patient has indicated the following medical conditions:

____

____

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

Antibiotic Prophylaxis Yes ___ No ___

Interruption of anticoagulants Yes ___ No ___

How long before and after treatment? ____

Anesthetic Restrictions: Yes ___ No ___

Is epinephrine ok?: Yes ___ No ___

Type of antibiotic allowed/recommended: ____

Any additional comments?

____

____

____

Physician (Please Print) ____

Physician Signature ____

Date: __________________________________

We appreciate your assistance in providing optimum care for this patient. Please have physician sign and fax back as soon as possible. Thank you.

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