



## MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dear Doctor,

Our mutual patient, \_\_\_\_\_ is scheduled for dental treatment.

Treatment may include:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Radiographs                         | <input type="checkbox"/> Apicoectomy |
| <input type="checkbox"/> Root Canal Therapy                  | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local anesthetic (with epinephrine) |                                      |

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: \_\_\_\_\_
- Type of pain medication allowed/recommended: \_\_\_\_\_
- Any additional comments: \_\_\_\_\_

\_\_\_\_\_  
*Physician's Name (please print)*

\_\_\_\_\_  
*Physician's Signature*

\_\_\_\_\_  
*Date*