Medical Clearance Form

Dear_____MD Date of Request _____

Patient Name:_____ Patient DOB_____

Our mutual patient presented to our office for comprehensive dental care. This may include dental cleaning, radiographs, fillings, root canals, dental restorations or extractions and may require use of local anesthetic and/or Nitrous Oxide. Please evaluate his/her medical condition and report back to us, in writing, with the following information. Thank you.

Findings/Recommended Dental Tx:

_____

_____

_____

**********TO BE COMPLETED BY PHYSICIAN**********

Name of Reporting Physician:_____ Date of Report: _____

Address of Reporting Physician: _____

Phone No of Reporting Physician: _____

1. Known medical conditions:

_____

_____

2. Current medications:

_____

_____

3. Known allergies:

_____

_____

4. Are there any special precautions or contraindications to dental treatment? (please be as specific as possible)

_____

_____

5. Does this patient require antibiotic prophylaxis, prior to dental cleanings and/or fillings, extractions? Yes or No

If yes, please specify: _____

6. Do you feel this patient can be safely treated in the dental office setting? Yes or No

Signature of Physician: _____