LEGACY

DENTAL SERVICES

Medical Clearance Form for Dental Treatment

Patient: _____ DOB: _____

Dear Dr. _____,

Our mutual patient, _____, is scheduled for dental treatment.

Treatment may include:

_____ Cleaning (simple or deep)

_____ Nitrous Oxide

_____ Fillings, Crowns, Bridges

_____ Extractions (simple or surgical)

_____ Radiographs

_____ Local Anesthetic (with epinephrine)

_____ Root Canal Therapy

_____ Other: _____

The patient has indicated the following medical conditions: _____

_____

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 mediation allowed/recommended: _____

Any additional comments: _____

_____

Physician Name (Please Print): _____

Physician Signature: _____ **Date**: _____

We appreciate your assistance in providing optimum care for our patient.