Queensgate Family Dentistry

"Only brush the ones you want to keep"

MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date: ___________________________

Patient: ____ DOB: ______________

Attn: ____

Dear Dr.____

Our mutual patient __________________________________is scheduled for dental treatment.

Treatment may include:

__ Cleaning (routine or deep)   __ Root Canal Therapy

__ Radiographs   __ Local Anesthetic

__ Restorative (Fillings, Crowns)   __ Other _____________________________________

__ Oral Surgery   ____

Please evaluate the patients' medical history and advise us of any special considerations that should be made.

******Check here if patient is clear for dental treatment at this time: Yes____ No_____***

***** If Patient has medical limitations, please check each box and add comments:***

Antibiotic prophylaxis   Yes ___ No ___

Interruptions 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: ___________________________________

Additional Comments: ____

____

Provider Name: ________________________________ Specialty: ___________________________

Signature: ____________________________________ Date: _____________ Phone: ___________________

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