

FAMILY DENTISTRY

13145 VETERANS MEMORIAL DR. HOUSTON, TX 77014 TEL. 281-580-4830

FAX – 855-313-5067

Medical Clearance Record

To Doctor _____

Clinic _____

Phone _____ Fax _____

Our Mutual Patient _____ D.O.B. _____

Has noted the following conditions(s) in a routine health history:

_____ Heart Murmur _____ Rheumatic Fever _____ Pacemaker

_____ Artificial Joints, Pins _____ Synthetic Hernia Repair _____ Taken Fen-Phen,
Screws or Heart Valves Piondimin or Redux

_____ Bleeding Disorder or Taking Blood Thinners

_____ Other _____

Treatment recommended: _____

Does this patient require prophylactic Antibiotic Coverage prior to dental treatment? Yes or No

1. If no, please state reason _____

Oral regimen you recommend:

RX ___ Amoxicillin ___ Clindamycin ___ Keflex ___ Zithromax ___ Biaxin

2. Please recommend the following local anesthetic:

_____ Plain lidocaine without EPI

_____ 2% lidocaine 1:1000,000 with EPI

_____ Mepi vacaine without EPI

_____ Other please specify _____

3. Medication Allergies _____

4. Please print a brief description of the patients' condition and any additional precautions that you feel are beneficial:

Please fax this letter back to us. We must have this clearance form completed and signed before providing treatment. Thank you.

Physicians Name _____

Physicians Signature _____