**Medical Clearance for Dental Treatment**

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

Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Treatment may include:

\_\_cleaning (simple or deep) \_\_Root Canal Therapy

\_\_Radiographs \_\_Nitrous oxide

\_\_Fillings, Crowns, Bridges \_\_Local anesthetic (with epinephrine)

\_\_Extraction (simple or surgical \_\_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 medication allowed/ recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# We appreciate your assistance in providing optimum care for this patient. Please have *physician sign* and fax to: Smiley Dental at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_