BRIGHTON DENTAL MULTISPECIALTY PRACTICE
ORAL & MAXILLOFACIAL SURGERY
3019 Brighton 1st Street, Brooklyn, NY 11235
Phone: (718) 366 0070 | Fax: (917) 997 9746 | e-mail: dmd@brightonoralsurgeon.com
www.brightonoralsurgeon.com

MEDIAL CLEARANCE FOR DENTAL TREATMENT

SECTION 1: To be completed by Brighton Oral Surgeon

Date: ____/ ____/ ________

Patient Name: ____ D.O.B ______/ ______/ _______

Dear Dr. ____

Our mutual patient, ____________________________________ is scheduled for Dental Treatment.

Treatment may include:

- ☐ Bone graft
- ☐ Radiographs
- ☐ Extractions
- ☐ Nitrous Oxide
- ☐ Local anesthetic (with epinephrine)
- ☐ IV Sedation
- ☐ Apicoectomy
- ☐ Sinus augmentation

SECTION 2: To be completed by Medical Practice

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 treatment: __________________ How long 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 Phone Number: ______________________________

______________________________	____________________	_______/______/_______
Physician Name (please print)	Physician Signature	Date