ADVANCED DENTAL SPECIALTY

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MEDIAL CLEARANCE FOR DENTAL TREATMENT

SECTION 1: To be completed by Advanced Dental Specialty

Date: ____/ ____/ _____

Patient Name: _____ D.O.B _____/ _____/ _____

Dear Dr. _____

Our mutual patient, _____ is scheduled for Dental Treatment.

Treatment may include:

- ☐ Cleaning
- ☐ Radiographs
- ☐ Extractions
- ☐ Nitrous Oxide
- ☐ Local anesthetic (with epinephrine)
- ☐ IV Sedation
- ☐ Root Canal Therapy

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