CHATHAM DENTAL ARTS
587 Old Graham Road
PO Box 582
Pittsboro, NC
27312
Phone: (919)542-4911

Medical Clearance for Dental Treatment

Date:_____
Attn:_____

Patient:_____ DOB: _____
Dear Dr. _____

Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

___ Cleaning (simple or deep)
__ Radiographs
___ Fillings, Crowns, Bridges
___ Extraction (simple or surgical)
__Root Canal Therapy
__Nitrous Oxide
__ Local Anesthetic (with epinephrine)
__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: _____

Any additional comments? _____
_____
_____

Physician (please print) _____

Physician Signature _____

We appreciate your assistance in providing optimum care for this patient.
Please have physician sign and fax to above.