CHATHAM DENTAL ARTS
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27312
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Medical Clearance for Dental Treatment

Date: _____

Attn: _____

Patient: _____

Date of Birth: _____

Dear Dr._____,

Our mutual patient, _____is scheduled for dental treatment.

Treatment may include:

___Cleaning (simple or deep scale)

___Radiographs

___Fillings, Crowns, Bridges, Implants

___Extraction (simple or surgical)

___Root Canal Therapy

___Nitrous Oxide

___Local Anesthetic (with epinephrine)

The patient has 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___; if so, 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 and sign) _____

We appreciate your assistance in providing optimum care for this patient. Please fax to (919)542-5714.