More Smiles of Beverly

2407 W 104th St

Chicago, IL 60655

773-980-8900

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Medical Clearance for Dental Treatment

Date:_____ **MD Phone:**_____
Attn: _____ **MD Address:** _____
MD Fax: _____
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**
___ **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.