

More Smiles of Beverly

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Chicago, IL 60655

872-703-3095

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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)

Root Canal Therapy

Radiographs

Nitrous Oxide

Fillings, Crowns, Bridges

Local Anesthetic (with epinephrine)

Extraction (simple or surgical)

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.