More Smiles of Beverly
10400 S. Western Avenue

Chicago IL,60643

773-980-8900

Fax 773-423-2808

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.