

Medical Clearance for Dental Treatment

Date: _____

Dear Dr.: _____ Phone #: _____

Our Mutual Patient, _____ Birthdate: _____
is scheduled for dental treatment,

Treatment May Include:

<input checked="" type="checkbox"/> Cleaning (simple or deep)	<input checked="" type="checkbox"/> Root Canal Therapy
<input checked="" type="checkbox"/> Radiographs	<input checked="" type="checkbox"/> Nitrous Oxide
<input checked="" type="checkbox"/> Fillings, Crowns, Bridges	<input checked="" type="checkbox"/> Local Anesthetic
<input checked="" type="checkbox"/> Extraction (simple or surgical)	Other _____

The patient has indicated the following medical conditions:

*** Please evaluate this patients 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: _____

Type of Pain Med. Allowed/Recommended: _____

Any Additional Comments: _____

Physician Name: _____
(please print)

Physician Signature: _____

Date: _____

We appreciate your assistance in providing optimum care for this patient
Please have physician sign and fax to: (407)-886-6625

Apopka Dental Art
1706 E Semoran Blvd.
Suite 106
Apopka, FL 32703
Office: (407)-886-8817
Fax: (407)-886-6625

I hereby Authorize my Dental Care Giver to receive and use my protected medical information for the purpose of documenting any and all medical clearance prior to dental treatment. I am confirming my authorizing for use and disclosure of the PHI described in this form with the people named in this form.

Patient's Signature