Medical Clearance for Dental Treatment

Commonwealth Dentistry

Date:_____ Attention:_____

Patient:_____ DOB:_____

Dear Dr. _____

Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

__ Cleaning (simple or deep)
__ Radiographs
__ Filling, crowns, or bridges
__ Extraction (simple or surgical)
__ Root Canal Therapy
__ Nitrous Oxide
__ Local Anesthetic with epinephrine
__ Other _____

The patient has indicated the following medical conditions

Please evaluate the patients medical history and advise us of any special considerations that should be made: _____

Antibiotic Prophylaxis: __ Yes __ No
Interruption of anticoagulants __ Yes __ No
If yes, how long after treatment? _____
Anesthetic Restrictions __ Yes __ No
Epinephrine Restrictions __ Yes __ No

Type of Antibiotic allowed/recommended:_____

Type of pain medication 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:

Commonwealth Dentistry Offices:

Midlothinan	Crewe	Colonial Heights	Prince George	Richmond	Kenbridge	Palmyra
(804) 739-4321	(434) 305-1112	(804) 520-8918	(804) 862-4414	(804) 320-1695	(434) 305-1113	(434) 589-5503