Deluxe Dental
DENTISTRY FOR KIDS & ADULTS
Phone: (248) 274-4020

Medical Clearance For Dental Treatment

Date:_____ Attention:_____

Patient Name:_____ Date of Birth:_____

Our mutual patient, as noted above, is scheduled for dental treatment at our office. Treatment may include:

- ☐ Cleaning (simple or deep)
- ☐ Radiographs (x-rays)
- ☐ Fillings, Crowns, Bridges
- ☐ Extraction (simple or surgical)
- ☐ Root Canal Therapy
- ☐ Nitrous Oxide
- ☐ Local Anesthetic (with Epinephrine)
- ☐ Other:_____

The patient has indicated the following medical conditions:

Dentist Comments:

_____ _____ _____
Dentist Name (Please Print) Dentist Signature Date

Physicians: Please complete the section below.

Evaluate this patient's medical history and advise us of any special considerations that should be made.

Does the patient require antibiotic prophylaxis? ☐ Yes ☐ No

Reason for prophylaxis:_____

Does the patient require an interruption of anticoagulant treatment? ☐ Yes ☐ No

How long before and after treatment?_____

Are there any restrictions anesthetic for this patient? ☐ Yes ☐ No

Is the use of epinephrine okay? ☐ Yes ☐ No

Type of antibiotic that is allowed/recommended for patient:_____

Type of pain medication that is allowed/recommended for patient:_____

Additional comments:

_____ _____ _____
Physician Name (Please Print) Physician Signature Date

We appreciate your assistance in providing optimum care for this patient. Please have physician fax signed form to:
Deluxe Dental Flint Fax: 810-259-2073 Phone: 810-820-7766