MEDICAL CLEARANCE FOR DENTAL TREATMENT

Patient's Name:_____ D.O.B:_____ Date of Last Physical Exam:_____

Dear Physician: Please complete this form entirely so that we can safely render the best possible dental care for our mutual patient. Your assistance is greatly appreciated.

Dental treatment that can potentially be rendered includes, but is not limited to: cleanings (prophylaxis), fluoride application, radiographs, resin restorations (including sealants), stainless steel crowns, extractions, and the administration of nitrous oxide ("laughing gas").

We also use the following types of **local anesthetics**: 2% lidocaine with 1:100,000 epinephrine, 4% articaine with 1:100,000 epinephrine, and 3% mepivicaine with no epinephrine.

Please indicate if the patient has any of the following medical conditions listed below:

☐ Heart Disease	☐ History of Cardiac Surgery
☐ Organ Transplant	☐ Bone Marrow Transplant
☐ HIV/AIDS	☐ Seizures/Epilepsy
☐ Sickle Cell Disease	☐ Hepatitis Type A/B/C
☐ Rheumatic Fever	☐ Cystic Fibrosis
☐ Diabetes Type I or II	☐ Sleep Apnea
☐ Abnormal Bleeding/Hemophilia/Thalassemia	☐ Cerebral Palsy
☐ History of Blood Transfusions/Dialysis	☐ Tuberculosis
☐ History of Cancer/Tumors	☐ Other:_____

Based on the patient's medical history, do you recommend:

- **Antibiotic prophylaxis prior to dental treatment?** ☐ **Yes** ☐ **No**
- **Nitrous oxide ("laughing gas") use?** ☐ **Yes** ☐ **No**

If the patient requires antibiotics prophylactically, which type/dosage do you recommend?

_____

_____

Do you have any other additional comments/special precautions for us to follow?

_____

_____

_____ _____ _____

Physician's Name **Physician's Signature** **Date**