Medical Clearance for Dental Treatment

Date:

Attn:

Patient: _____ Birthdate: _____

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 Therapy
__ 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: _____
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:

Audubon Dental Group
6120 Magazine Street
New Orleans, LA 70118
Office: (504)891-7471

Fax: (504) 891-8919