Lynn
Family Dentistry
OUR FAMILY CARING FOR YOURS

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Milltown, NJ 08850
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MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date:_____
Attn:_____

Patient: _____ DOB: _____
To The Office Of: _____
Phone: _____
Fax: _____
Address: _____
_____

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
___Local Anesthetic (without epinephrine)
___ 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: _____

Any additional comments? _____
_____
_____

Physician/Provider (please print) _____

Physician/Provider Signature _____

We appreciate your assistance and prompt response in providing optimum care for our patient.
Please have **physician/provider sign** and fax to the above.