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) ___ Root Canal Therapy

___Radiographs ___Nitrous oxide

___Fillings, Crowns, Bridges ___Local anesthetic (with epinephrine)

___Extraction (simple or surgical) ___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

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 the physician sign and fax to:

Battery Park Dental Group
375 South End Avenue
New York, NY 10280
F: (212) 619-4098