

from the desk of

NINA KUMAR, DDS

medical clearance

address

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PATIENT NAME: _____

DOB: ____ / ____ / ____

Pt reports the following medical history:

Patient reports taking the following medications:

Pt requires extensive dental treatment. Please clear patient for dental treatment and provide any recommendations for treatment.

*****TO BE COMPLETED BY THE PHYSICIAN*****

Name of reporting Physician: _____

Address of reporting Physician: _____

Phone # of reporting Physician: _____

Date of last exam:

1. Verify list of all current medications:

2. Verify all known medical conditions:

3. List of known drug allergies: _____

4. Are there any special precautions &/or contra-indications to dental treatment?

Yes No if so, please specify: _____

5. Antibiotic prophylaxis: Yes No

6. Is there a need for interruption of medications?:

Yes No if so, please specify: _____

7. Anesthetic restrictions:

Yes No if so, please specify: _____

→ Is Epinephrine OK? Yes No

8. Any additional comments:

Physician Signature _____

Date: ____ / ____ / ____