Medical Clearance for Dental Treatment

Date: _____

Patient Name: _____ Birthdate: _____

Dear Doctor 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 (with epinephrine)

__ Other _____

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:

Tenafly Dental Spa
2 Dean Drive, 3rd Floor
Tenafly, NJ 07670
Phone: 201-541-4002
Fax: 888-245-0308
TenaflyDentalSpa@gmail.com