SMILEY DENTAL
KIDS, ADULTS & SENIORS

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:

_____

_____

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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: Smiley Dental at_____