

**Physician Report and
Medical Clearance for Dental Services**

Dear Dr. _____

Date of Request: _____

FAX: _____

Phone: _____

Our mutual (shared) patient, _____, has chosen to proceed with their dental care in our office. In order to aid in his/her treatment, could you please complete this medical clearance form.

The patient has reported the following conditions and medications:

Please evaluate his/her medical condition and report back to us, in writing:

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

Name of reporting Physician: _____

Address of reporting Physician: _____

Phone # of reporting Physician: _____

Date of last exam: _____

1. List of all current medications:

2. List of known medical conditions:

3. List of known drug allergies:

4. Are there any special precautions or contra-indications to dental treatment?
(Please be as specific as possible.)

5. Do you feel this patient can be safely sedated in the dental office setting if necessary?

YES

NO

6. Does this patient need to be given prophylactic antibiotics according to the new (April 2007) American Heart Association guidelines?

YES

NO

7. Is this patient's blood pressure under control?

YES

NO

8. What are the patient's most recent blood values *(if applicable)*?

Date drawn: _____

INR: _____

HbA1c: _____

PT/PTT _____

Platelet count: _____

Signature of Physician _____

Date: _____

For your convenience, your response may be **faxed to (760) 436-2083**. If you have any questions regarding the above request, please contact **Dr. Snow at (760) 436-7222**.

Thank you for your immediate attention to this matter!

Sincerely,
Dr. James Snow