TRUDENT CLINICS MEDICAL CLEARANCE CONSENT

Medical Clearance For Dental Treatment

Date: _____ Attn: _____

Dear Dr. _____

Our mutual patient, _____

is scheduled for the following dental treatments in our office:

_____
_____

_____

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:

_____

Physician Name (please print) _____

Physician Signature _____ Date _____

We appreciate your assistance in providing optimum care for this patient.

Please have the physician sign and email to: info@trudentclinics.com

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