

CHATHAM DENTAL ARTS
587 Old Graham Road
PO Box 582
Pittsboro, NC
27312
Phone: (919)542-4911

Medical Clearance for Dental Treatment

Date: _____

Attn: _____

Patient: _____

DOB: _____

Dear Dr. _____

Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

Cleaning (simple or deep)

Root Canal Therapy

Radiographs

Nitrous Oxide

Fillings, Crowns, Bridges

Local Anesthetic (with epinephrine)

Extraction (simple or surgical)

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: _____

Any additional comments? _____

Physician (please print) _____

Physician Signature _____

We appreciate your assistance in providing optimum care for this patient.
Please have physician sign and fax to above.