CHANDLER Dental Health

DATE SENT: _____ DATE REVIEWED: _____

Dear Doctor_____,

We are planning to proceed with dental treatment on our mutual patient, _____ .

He/she indicates a history of the following medical problems and listed medications:

_____

_____

- Should any of these medications be modified? □Yes □No If yes, what modifications?

_____

- Is Antibiotic Prophylaxis required? □Yes □No If yes, what is recommended regimen?

_____

- Can the patient proceed with dental treatment? □Yes □No If no, Please provide details.

_____

- Please initial _____ if NO modifications are necessary and you have cleared patient for dental treatment.

PHYSICIAN SIGNATURE _____ DATE _____

Please review, sign and fax this document to our office as soon as possible to prevent a delay of our patient's treatment. Thank you for your valuable time in this matter.

Chandler Dental Health
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