Chandler Dental Health

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Medical Clearance Form

Dear Doctor: _____

We are planning to provide dental care to our mutual patient

Patient Name: _____ * _____ * _____ _____
Last First MI Preferred Name

Date of birth: _____

Patient presents with the following significant medical issues:

- ☐ Condition that may require antibiotic premedication
- ☐ Abnormal BP reading in our office
- ☐ Other
- ☐ Coagulation issues/blood thinning medications
- ☐ Taking the following medication

Additional information: *

_____

_____

The following dental procedures are planned: *

☐ Teeth cleaning ☐ Fillings / Crowns ☐ Tooth extarctions ☐ Other

Additional information:

_____

_____

The procedure(s) will require local anesthetic? * ◯ Yes ◯ No

Please advise which of the following applies to our mutual patient:

- ☐ Dental treatment is not approved at this time
- ☐ Patient may proceed with dental treatment after the following modifications:
- ☐ Patient does not require any modifications to their medical treatment and they are cleared for treatment
- ☐ Other

Additional information:

_____

_____

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

Signature _____ **Date** _____

Response Date: _____