

MEDICAL CLEARANCE

DATE: _____

DATE OF BIRTH: _____

PATIENT NAME: _____

MEDICAL CONCERN: _____

We are requesting an update on the patients:

1. Medical condition
2. Recommendations
3. Clearance for dental treatment

The patient's dental treatment may include:

1. Local anesthetic with 2% Lidocaine (1:000,000 epinephrine) or 3% Carbocaine (no epinephrine).
2. Surgical procedures including dental extractions.
3. Invasive dental procedures causing transient bacteremia.
4. Other: _____

DENTIST NAME: _____

MEDICAL CONSULT

DATE: _____ PHYSICIAN NAME: _____

PHONE NUMBER: _____ FAX NUMBER: _____

1. MEDICAL UPDATE: _____

2. RECOMMENDATIONS: _____

3. CLEARANCE FOR DENTAL TREATMENT: YES NO
IF NO, REASON WHY? _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Bethesda

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