THREE RIVERS ENDODONTICS

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MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date: _____

Patient Name: _____ Date of Birth: _____

Dear Doctor,

Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

- ☐ Radiographs
- ☐ Root Canal Therapy
- ☐ Local anesthetic (with epinephrine)
- ☐ Apicoectomy
- ☐ Other _____

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's Name (please print)

_____ _____
Physician's Signature *Date*

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