The Studio of

LUXURY SMILES DESIGN

Medical Clearance For Dental Treatment

Date: _____ Attn: _____

Dear Dr. _____

Our mutual patient, _____

is scheduled for the following dental treatments in our office:

_____

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: _____

Type of pain medication allowed / recommended: _____

Any additional comments: _____

Physician Name (please print) _____

Physician Signature _____ Date _____

We appreciate your assistance in providing optimum care for this patient.
Please have physician sign and fax to **909-606-0854**

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