HSR Dental Booth

Royal heights, 255, 17th Cross Road, Sector 6, HSR Layout, Bengaluru, Karnataka 560102
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Medical Clearance for Dental Treatment

Date:_____

Patient:_____ DOB: _____

Dear Dr. _____
Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:
___ Cleaning (simple or deep)
___ Root Canal Therapy
___ Radiographs
___ Nitrous Oxide
___ Fillings, Crowns, Bridges
___ Local Anesthetic(with epinephrine)
___ Extraction (simple or surgical)
___Other: _____

The 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: _____
Any additional comments?
_____
_____
_____

Physician Signature: _____
Physician Name: _____
Date: _____

We appreciate your assistance in providing optimum care for this patient. Please have a physician sign and fax to above.