Request for Medical Clearance

Our Mutual Patient:

Patient Name _____
Date of Birth _____
Home Phone _____

Treatment may include:

Prophylaxis	Root Canal Therapy	Local Anesthetic	Extraction (Simple or Surgical)
Radiographs	Fillings, Crowns, Bridges	Implants	Periodontal Scaling and Root Planning

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.

- ○ Prophylactic antibiotics
- ○ Interruption of anticoagulants:
  How long before treatment: _____. How long after treatment: _____.
- ○ Anesthetic restrictions
- ○ Radiology restrictions
- ○ **Treatment NOT recommended at this time.** (We ask that you contact our office directly to discuss other treatment options.)

Once signed, please return original form to our office within 7 days.
(Please make a copy for your records.)

Physician Name: _____ **Date:** _____

Physician Specialty: _____ **Office Phone Number:** _____

Special Instructions:

Please contact my office if you have any questions. We thank you for assisting us in our efforts to maintain good dental health for our patient.

Kindly,

Danielle D. Zhu, DDS PA

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