PREMIERE DENTAL

MEDICAL CLEARANCE FORM

In our continuing efforts to ensure the safety of our mutual patients, we request your response to our questionnaire. Please make any necessary suggestions or comments. If you would like to discuss any particular aspect of the planned treatment, please call and ask for

Dr. _____

PATIENT NAME: _____ DOB:_____

PROPOSED TREATMENT: _____

ANESTHETIC/MATERIALS: _____

SIGNATURE OF DENTIST: _____

FOR PHYSICIAN (Please respond and comment when necessary to marked questions)

- DOES THE PATIENT NEED TO BE PREMEDICATED WITH ANTIBIOTICS?
  _____
- CAN DENTAL TREATMENT BE ADMINISTERED WITHOUT RISK TO THE PATIENT'S HEALTH?
  _____
- CAN LOCAL ANESTHETICS BE ADMINISTERED?
  _____

1. LIDOCAINE 2% WITH EPINEPHRIN 1:1.00,00 YES/NO
2. CABOCAINE 3% WITHOUT EPINEPHRINE YES/NO
3. CITANEST 4% WITHOUT EPINEPHRINE YES/NO

- PLEASE LIST MEDICATIONS WITH DOSAGES AND SIDE EFFECTS (ATTACH ADDITIONAL SHEETS IF NEEDED)
  _____

- IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT THE PATIENT'S HEALTH THAT WOULD BE RELEVANT TO DENTAL TREATMENT?
  IF YES, WHAT? _____
  _____

I, _____ HEREBY CLEAR PATIENT FOR ABOVE PLANNED TREATMENT

SIGNATURE: _____ DATE: _____

PHONE: _____ ADDRESS: _____