MEDICAL CLEARANCE FORM

Date: _____

Patient Name: _____ *Telephone Number:* _____

Date of Birth: _____ *Social Security Number:* _____-_____-_____

Physician's name: _____ *Contact Phone Number:* _____

Fax Number: _____ *Email:* _____

Planned dental procedures may include x-rays, subgingival cleanings, fillings, root canals, extractions.

Proposed Procedure:

_____

_____

_____

IS THE PATIENT AN ACCEPTABLE CANDIDATE FOR THE ABOVE PROCEDURE?

☐ *YES* ☐ *NO*

SHOULD PROPHYLACTIC ANTIBIOTICS BE PRESCRIBED?

☐ *YES* ☐ *NO*

IF YES, WHICH ONES? _____ *DISPENSE:* _____

CAN LOCAL ANSTHESIA WITH EPINEPHRINE (1:100,000) BE USED?

☐ *YES* ☐ *NO*

IF THE PATIENT IS TAKING ANTICOUGLANT DRUGS: (EXAMPLE: PLAVIX, COUMADIN, EXT.)

ANTICOUGLANT MEDICINE CAN BE DISCONTINUED _____ DAYS BEFORE THE DENTAL PROCEDURE AND RESUMED WITHIN ____ DAYS AFTER THE DENTAL PROCEDURE.

ANY OTHER PRECAUTIONS TO BE TAKEN:

_____

_____

_____

This form can be returned by email at: supersmiles@ADC4Smiles.com or by fax at: (219)663-3373, Attention Dr. Danny Hayes, DMD

_____

Patient Name (Printed) ***Date of Birth***

_____

Patient (Parent/Guardian) Signature ***Date***

_____/_____

Doctor/Staff Signature ***Date***