



NEW ENGLAND SMILES

Medical Clearance for Dental Treatment

Date: _____

Attn: _____

Patient: _____ Birthdate: _____

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: _____

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: Smiley Dental at _____