Clearance For Dental Surgery

Return via: email: info@inmanparkdentistry.com
Fax: (404) 214-9414 Voice: (404) 589-7799
Mail: 245 N Highland Ave NE, STE 260. Atlanta, GA 30307

Patient Name: _____ Date: _____

DOB: _____ Type of Surgery: _____
(e.g. extractions, implant placement, sinus lift, etc.)

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Our mutual patient needs dental surgery. As an out-patient, general dentistry clinic, we only perform surgeries on ASA Class I or II patients. To ensure our doctors have a thorough understanding of the patient's medical condition, please complete the following:

- Is the patient currently on **blood thinners or anticoagulants**? YES / NO
  If so, please list most recent PT/INR test result/date: _____
  (Note: We do NOT want the patient to discontinue their medication routine).
- Has the patient ever had treatment with **bisphosphonates** for osteoporosis? YES / NO
- Is **antibiotic prophylaxis** needed for this patient? YES / NO

  For what condition? _____
- Are there any specific restrictions (or recommendations) for post-operative **pain** YES / NO

  management medications for this patient? _____
- Local anesthetics containing 10 mcg/ml of **epinephrine** are routinely used in dental surgery.

  Is there a reason we should NOT use that medication on this patient? YES / NO

  For what condition? _____
- Additional comments?_____

  _____

  _____

  _____

Please complete the below details before sending back to Inman Park Dentistry:

Physician's Name: _____ **Date:** _____

Phone: _____

Email: _____ **Signature:** _____