

PATIENT NAME: \_\_\_\_\_

**PATIENT INFORMATION: PREVENTION OF BACTERIAL ENDOCARDITIS**

RECOMMENDED ANTIBIOTIC REGIMEN FOR ORAL PROCEDURES IN PATIENTS WHO ARE AT RISK.

\_\_\_ AMOXICILLIN - 2.0 GRAMS (4 CAPSULES, 500 MG EACH) ONE HOUR BEFORE THE DENTAL APPOINTMENT

**FOR AMOXICILLIN/PENICILLIN ALLERGIC PATIENTS:**

\_\_\_ CLINDAMYCIN - 600 MG ORALLY ONE HOUR BEFORE PROCEDURE

OR

\_\_\_ CEPHALEXIN - 2.0 GRAMS ORALLY ONE HOUR BEFORE PROCEDURE

OR

\_\_\_ AZITHROMYCIN - 500 MG ORALLY ONE HOUR BEFORE PROCEDURE

Recommended by the American Heart Association, JAMA September 1997

I certify that I have read and understand the above information and it is correct to the best of my knowledge. I understand that the information I have given today will be held in the strictest of confidence. It is my responsibility to inform this office of any changes in my medical status. The patient by the signature below, or if a minor, the parent or responsible party, that permission is granted for treatment.

Date: \_\_\_/\_\_\_/\_\_\_ Tooth # \_\_\_\_\_

Patient's signature (Parent or guardian if minor) \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Tooth # \_\_\_\_\_

Patient's signature (Parent or guardian if minor) \_\_\_\_\_