

Medical Clearance for Dental Treatment

Date:

Patient: _____ Birthdate: _____

Dear Dental Provider,

Our mutual patient is in need of dental treatment.

Treatment may include (any exclusions will be ~~fixed~~ through):

- Cleaning (simple or deep)
- Radiographs with appropriate abdominal shielding
- Fillings, Crowns, Bridges
- Extraction (simple or surgical) or Root Canal
- Nitrous oxide, Local anesthetic (with epinephrine ok)

Please see the attached clinic note for any additional medical conditions or pregnancy complications as well as a medication list.

Antibiotic prophylaxis, if indicated, may include amoxicillin, amoxicillin-clavulanate, azithromycin, cephalexin (or another cephalosporin), clindamycin, metronidazole.

Pain medication, if indicated, may include acetaminophen, codeine, hydrocodone or oxycodone. I recommend using narcotic medications sparingly on an as-needed basis (dispense #20 or fewer).

Physician Name (please print) _____

Physician Signature _____