South Cove CHC Dental Department

Medical Clearance Form

Patient:_____ DOB: _____ MR#: _____

Dear Dr. _____,

Our mutual patient named above will be needing the following treatments:

_____Cleaning (simple or deep) _____ Radiographs

_____ Fillings, Crowns, Bridges _____ Root Canal Therapy

_____ Extractions (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 mediation allowed/recommended: _____

Any additional comments:

_____

_____

Physician Name (Please Print): _____

Physician Signature: _____ Date: _____

We appreciate your assistance in providing optimum care for this patient.

Please sign and fax form to: South Cove Community Health Center

145 South Street Boston MA 02111

Phone: 617-457-6617 Fax: 617-457-6600