Medical Clearance Form

Patient's Name: ________________________________ Date: ____________________________

Dear Doctor,

Our mutual patient has presented for dental treatment with the following medical problem(s):

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The following treatment is scheduled in our dental office: ________________________________
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Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, the history and status of any infectious diseases, and any medical condition that would possibly compromise the healing process.

Ordinarily, local anesthesia is obtained with 2% Lidocaine with 1:100,000 Epinephrine. The procedures may involve radiographs, bleeding and use of biomaterials.

Please provide the progress notes of the patient along with this form.

Check ALL that apply:

- ☐ **OK** to Proceed with dental treatment, **NO** special precautions, and **NO** prophylactic antibiotics needed.
- ☐ Antibiotic prophylaxis **IS REQUIRED** for dental treatment.
- ☐ Other Precautions are required. Please List: ____________________________________
  ____
- ☐ **DO NOT** proceed with dental treatment. Please give reason: ________________________
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Name of the Physician: ____
Signature: ____ Date: _______________________

Please send the form to our office:
Fax: (425) 644-1564
Email: info@bellevuedentist.com