DENTAL ASSOCIATES OF THE NORTH SHORE
400 JERICHO TURNPIKE
SYOSSET, NY 11791
516-348-8500
www.ShineDentalGroup.com

Medical Clearance for Dental Treatment

Date:____________________
Attn:____________________

Patient:________________________________ DOB: ________________
Dear Dr. ______________________________

Our mutual patient, ______________________________________ is scheduled for dental treatment.

Treatment may include:

___ Cleaning (simple or deep)
___ Radiographs
___ Fillings, Crowns, Bridges
___ Extraction (simple or surgical)
___Root Canal Therapy
___Nitrous Oxide
___ Local Anesthetic (with epinephrine)
___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: ____________________________

Any additional comments? ____
____
____

Physician (please print) ____

Physician Signature ____

We appreciate your assistance in providing optimum care for this patient.
Please have physician sign and fax to above.