



## MEDICAL CLEARANCE FORM

### PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Gender:  Male  Female  Other  
Facility / Care Center (if applicable): \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### PROPOSED DENTAL TREATMENT

Dental Provider: \_\_\_\_\_

- Dental cleaning
- Local anesthesia
- Fillings and crowns
- IV sedation and monitored anesthesia care
- Extractions
- General anesthesia

### MEDICATION RECOMMENDATIONS

Is the patient currently taking anticoagulant or antiplatelet medication?  Yes  No

If YES, please list the date of the last dose: \_\_\_\_\_

If YES, please list medication(s) and most recent INR (if applicable): \_\_\_\_\_

Is antibiotic prophylaxis recommended for this patient?  Yes  No

If YES, please specify medication and instructions: \_\_\_\_\_

### MEDICAL CLEARANCE FOR DENTAL TREATMENT UNDER ANESTHESIA

Based on a medical evaluation, please indicate the patient's current status:

- Medically cleared** to undergo the planned dental treatment under anesthesia
- Medically cleared** for anesthesia with the following precautions: \_\_\_\_\_
- Not medically cleared** for anesthesia at this time. \_\_\_\_\_

*\*This clearance reflects the patient's current medical status and does not replace the anesthesia provider's independent evaluation on the day of the procedure\**

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Date