**Mobile Dental Clinic**

**Medical Clearance for Dental Treatment**

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Our mutual patient: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_**

is scheduled or needs to schedule dental treatment. Treatment may include:

\_\_ Cleaning (simple or deep) \_\_ Extractions (simple or surgical)

\_\_ Radiographs \_\_ Root Canal Therapy

\_\_ Fillings or crowns \_\_ Local Anesthetic with epinephrine

The patient has indicated the following medical conditions:

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Please evaluate this patient’s medical history and advise us of any special considerations that should be made.

Antibiotic prophylaxis: Yes \_\_ No \_\_

Type of antibiotic allowed/ recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interruption of anticoagulants: Yes \_\_ No \_\_

How long before and after treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthetic restrictions: Yes \_\_ No \_\_

Is epinephrine ok? Yes \_\_ No \_\_

Type of pain medication allowed/recommended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please have physician sign and the fax to the Mobile Dental Clinic 847-618-4273 or email the form to the Program Manager, Angel Weathers, aweathers@nch.org