



Cleveland Clinic

DENTAL CLEARANCE FORM

Cleveland Clinic Heart & Vascular Institute

Thoracic and Cardiovascular Surgery Outpatient Center

9500 Euclid Avenue, Desk J4-1

Cleveland, OH 44195

Phone: 216-445-9614; Fax: 216-445-9608

*For scanning accuracy, affix patient label
within this outlined box.*



CCF370845

Surgeon's Name: _____

Patient's Name: _____

Patient's Clinic Number: _____

This patient is tentatively scheduled for open-heart surgery the week of: ____ / ____ / ____

Please complete this form and return via fax to 216-445-9608 as soon as possible, and bring a copy to your pre-operative clearance appointment.

Date of Patient's Last Dental Exam: ____ / ____ / ____

(Important Note: Dental exam including full mouth x-rays and / or panorex must have been completed within six months of the open-heart surgery date above. In addition, the patient must not have any signs of acute infection in order to be cleared for surgery.)

Does the patient have any acute dental infections? Yes No

If yes please document and call the surgeon at the number listed above.

Dentist's Name: _____

Dentist's Signature: _____ Date: ____ / ____ / ____ Time: _____

Phone Number: _____ Fax Number: _____

Thank you for your cooperation.