Northridge Dental Group Medical Clearance Form

Date _____

To: _____ From: _____

I hereby give permission and authorization to provide **Northridge Dental Group** with the information requested.

_____

Patient Name Patient Signature (or guardian) Date

Please advise if any precautions or limitations are necessary for the patient with respect to:

___ 1. Use of local anesthetic with epinephrine: ___ Yes ___ No

___ 2. Use of local anesthetic without epinephrine: ___ Yes ___ No

___ 3. Drug allergies or limitations on drugs - Do not prescribe _____

___ 4. Any precaution in the use of x-rays: ___ Yes ___ No

___ 5. Due to pregnancy, any limitation on x-rays: ___, antibiotics ___, pain medication ___?

___ 6. Is antibiotic premedication needed? ___ Yes ___ No

___ 7. Any precautions needed due to medical history with respect to dental treatment including, but not limited to, extractions, prophylaxis, periodontal surgery, root canals, fillings, crowns and bridges, dental implants, or other treatment? ___ Yes ___ No

If yes, please elaborate: _____

_____

Dentist's Special Note: _____

_____

_____

Please provide any additional pertinent information as it may affect dental treatment.

_____

_____

Signature: _____ M.D. Date: _____

Print Name: _____

Phone: _____ Fax: _____

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