STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
Dental Hygiene Committee of California
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DHCC PHYSICIAN'S CLEARANCE FORM

Dear Doctor:
Your patient, _____, has consented to participate as a patient for the California Clinical Dental Hygienist Examination that will take place on the following date _____. During this licensing exam, a dental hygienist candidate will scale and root plane (deep clean) a segment of the patient's dentition. Local anesthetic with a vasoconstrictor may be used. When there is any question as to the medical status of the patient, the patient's physician must be contacted to obtain a medical release for treatment. A potential problem(s) listed below has been identified which may influence the dental hygiene care to be delivered. This clearance form will be used to evaluate the patient's health prior to proceeding with the treatment as well as to determine any needed modifications for dental hygiene care.

Patient Name_____

DOB_____

I have consented to participate in the California Clinical Dental Hygienist Examination and authorize release of any medical or other information necessary to process this request for medical consultation.

_____ _____
Patient's Signature Date

Patient's reported medical condition which may warrant special consideration for dental hygiene treatment

_____

_____

In addition, the patient has indicated he/she is ***currently*** taking the following medications and or supplements:

_____

_____

_____

Proposed dental hygiene treatment: ☐ Exam and Radiographs ☐ Scaling and/or root planing

☐ Local Anesthesia, plain (without vasoconstrictor) ☐ Local Anesthesia with vasoconstrictor:_____

Medical information requested:_____

_____

_____

SECTION TO BE COMPLETED BY PHYSICIAN

Is the patient healthy enough to undergo the proposed treatment? *(Please initial)* ***YES***_____ ***NO***_____

Does the patient require antibiotic premedication for dental treatment? *(Please initial)* ***YES***_____ ***NO***_____

If yes, diagnosis of condition necessitating antibiotic prophylaxis:_____

Are there any contraindications or precautions for dental treatment? *(Please initial)* ***YES***_____ ***NO***_____
If yes, please explain:_____

_____

_____

Does the patient require any modification in his/her medical treatment in order to undergo dental hygiene treatment safely?
(Please initial) ***YES***_____ ***NO***_____ ***If yes, please explain:***_____

_____

_____

_____
Physician's Signature

Date_____ Time_____

Print Name_____
Office Address_____
City, State, Zip_____
Phone #_____FAX #_____

The original form must be submitted with your patient at check-in on the day of the examination with ORIGINAL signatures.