Audubon DENTAL GROUP
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New Orleans, LA 70118-5826
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Medical Clearance for Dental Treatment

Date:_____
Attn:_____

Patient:_____ DOB: _____
Dear Dr. _____

Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

___ Cleaning (simple or deep)
___ Radiographs
___ Fillings, Crowns, Bridges
___ Extraction (simple or surgical)
___Root Canal Therapy
___Nitrous Oxide
___ Local Anesthetic (with epinephrine)
___Other: _____

The patient has indicated the following medical conditions:

_____
_____
_____
_____
___

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

Antibiotic Prophylaxis: Yes___ No___
Interruption of anticoagulants: Yes___ No___
How long before and after treatment? _____
Anesthetic Restrictions: Yes___ No___
Is epinephrine OK?: Yes___ No___
Type of Antibiotic Allowed/Recommended: _____

Any additional comments?

_____
_____
_____
_____

Physician (please print)

_____

Physician Signature

_____

We appreciate your assistance in providing optimum care for this patient.
Please have physician sign and fax to above.