PARK DENTAL
J. Glavicic, DMD A. Saraydarian, DMD
560 Bergen Boulevard
Ridgefield, NJ 07657
(201) 945-4477

MEDICAL CLEARANCE FORM

Date:_____

To The Office Of: _____
_____
_____

Telephone#: _____ Fax#: _____

Dear_____:

We are writing this letter about our mutual patient

Name:_____ DOB:_____

Patient requires the following dental treatment:

____Routine Cleaning_____Extraction_____Root Canal_____Periodontal Treatment

Please provide **in writing**:

1. Clearance for dental treatment.
2. Any contraindications on medications or anesthetics.
3. Recommendation for antibiotic prophylaxis.
4. Blood thinner directions.

Thank you for your time and prompt response.

Sincerely,

Park Dental