Dental Medical Clearance Form Template

Title: Dental Medical Clearance Form Template

Patient Details

- **Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **Contact Number: _____**
- **Emergency Contact: _____**

Medical Information

- **Current Medications: _____**
- **Known Allergies: _____**
- **Previous Medical Conditions:**
  - ☐ **Cardiac Issues**
  - ☐ **Diabetes**
  - ☐ **Hypertension**
  - ☐ **Respiratory Illnesses**
  - ☐ **Other (Specify): _____**

Clearance for Treatment

The following clearance is provided based on the patient's health assessment.

Recommendations are listed below:

1. _____
2. _____
3. _____

Approval and Authorization

- ☐ **Cleared for dental procedures without restrictions**
- ☐ **Cleared with caution (specify): _____**
- ☐ **Not cleared; further examination required**

Physician's Signature and Date

- **Physician's Signature: _____**
- **Date: _____**