Dental Medical Clearance Form for Surgery

Title: Dental Medical Clearance Form for Surgery

Patient Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Contact Number: _____**
- **Email Address: _____**
- **Address: _____**

Referring Physician Information

- **Physician's Name: _____**
- **Specialty: _____**
- **Clinic/Hospital Name: _____**
- **Contact Number: _____**
- **Email Address: _____**

Medical History

- **☐ Diabetes**
- **☐ Heart Disease**
- **☐ High Blood Pressure**
- **☐ Respiratory Issues**
- **☐ Recent Surgeries (Specify): _____**

Surgical Clearance

The patient has been assessed and is medically cleared for dental surgery under the following conditions:

1. _____
2. _____
3. _____

Table for Vital Signs

Date	Blood Pressure	Heart Rate	Additional Notes

Physician’s Signature

- **Signature: _____ Date: _____**
- **Physician's Stamp (if applicable)**