Generic Dental Medical Clearance Form

Title: Generic Dental Medical Clearance Form

Patient Information

- **Full Name: _____**
- **Contact Information:**
  - **Phone: _____**
  - **Email: _____**

Medical Provider Details

- **Physician's Name: _____**
- **Office Address: _____**
- **Contact Number: _____**

Patient Health Assessment

- **☐ No known medical conditions**
- **☐ History of Heart Conditions**
- **☐ Diabetes**
- **☐ Allergies (specify): _____**
- **☐ Medications (list all): _____**

Medical Clearance Statement

Based on the medical evaluation, the patient is:

- **☐ Cleared for all dental treatments**
- **☐ Cleared with limitations (explain): _____**
- **☐ Not cleared (explanation required): _____**

Treatment Recommendations (if applicable)

1. _____
2. _____
3. _____

Table for Physician Comments

Observation Date	Findings	Physician Comments	Follow-up Date

Physician’s Signature

- **Signature: _____**
- **Date: _____**