Printable Medical Clearance Form for Dental Treatment

Title: Printable Medical Clearance Form for Dental Treatment

Patient Profile

- **Name: _____**
- **Age: _____**
- **Contact Number: _____**
- **Address: _____**

Health History

- **☐ No history of medical conditions**
- **☐ Cardiac Issues**
- **☐ Diabetes**
- **☐ Asthma or Respiratory Conditions**
- **☐ Other (Specify): _____**

Medications

- **List current medications: _____**
- **Dosage and Frequency: _____**

Clearance and Special Instructions

- **☐ Fully cleared for dental procedures**
- **☐ Cleared with restrictions: _____**
- **☐ Not cleared due to medical conditions**

Additional Instructions or Special Considerations

1. _____
2. _____
3. _____

Table for Medical Clearance Information

Date of Clearance	Physician's Initials	Restrictions (if any)	Follow-up Date

Physician Authorization

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