PINE GROVE
FAMILY DENTAL
Dr. Foutz • Dr. Harman • Dr. Niquette

MEDICAL CLEARANCE FORM

On the Medical History Form you completed, you identified that you have one or more coronary or other medical risk factors; including, but may not be limited to prosthetic joint; which could affect your planned dental treatment. For this reason, we ask that you have a physician complete and return this medical clearance form to us so that we can begin your treatment. We sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your dental care at our office to be as safe and comfortable as possible.

I hereby give my permission to release any pertinent medical information from medical records to Pine Grove Family Dental. All information will remain confidential.

Patient's name (print): _____ **DOB:** _____ **Today's Date:** _____

Physician's name: _____ **Phone:** _____

Address: _____

Treatment may include:

Cleaning (ultrasonic device)
Radiographs
Fillings, crowns, bridge
Local anesthetic w/epinephrine
Nitrous Oxide
Extraction (simple or surgical)

Please evaluate the patient's medical history and advise us of any special considerations that should be made:

Antibiotic Prophylaxis:	YES	NO
Interruption of anticoagulants:	YES	NO
Anesthetic Restrictions	YES	NO
Epinephrine Restrictions:	YES	NO

If yes to any of the above, please specify for how long after treatment: _____

Type of antibiotic allowed/recommended: _____

Dosage: _____ **Strength:** _____ **Duration:** _____

Type of pain medication allowed/recommended: _____

Additional comments: _____

_____

Physician's name (print): _____

Physician's signature: _____ **Date:** _____

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