JUNE GOODALL, DDS

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MEDICAL CLEARANCE FOR DENTAL TREATMENT

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Dear Doctor(s)

Our mutual patient listed above is in need of dental treatment. Please indicate below your recommendations, medical concerns and procedures that the patient may move forward with at this time.

Treatment may include:

_____ Cleaning	_____ X-rays for Carries	_____ 3D Scan to study bone
_____ Fillings	_____ Extraction(s)	_____ Implants
_____ Crowns	_____ Endodontics	_____ Orthodontics

_____ Other _____

Please indicate the patient's medical history, is the patient presently under routine care and medications he/she is presently taking and/or attach to this form or email.

_____

_____

_____

Please evaluate this patient's medical history and advise us of any special considerations that should be made. Circle Yes or No and explain.
1: Antibiotic prophylaxis Yes / NO Preferred Antibiotic and instructions
_____
2: Interruption of anticoagulants Yes / No If so which one and how long before and after treatment. _____
_____
3: Anesthetic restrictions Yes / No Is Epinephrine 1:100,00 OK? Yes / No
4: N2O Yes / No
5: Type of Antibiotics and instructions for dental infection you recommend for patients medical needs. _____
6: Type of pain medications allowed/recommended _____
_____

Additional information or comments: _____
_____
_____

Patient understands this information was requested and permits Doctors to forward to specialist who may be working with Dr. Goodall for patients dental needs.
Patient Signature: _____ **Date** _____

Physicians Name (please print) _____

Physicians Signature _____ **Date** _____

We appreciate your assistance in providing optimum care for this patient and expediting this information for Dr. Goodall. Please fax or email it back to our office, no cover needed.