

Dental Clearance Form

Patient information
Full name:
Date of birth:
Gender:
Contact information (email and/or number):
Address:
Emergency contact (name and contact information):
Insurance information:
Medical history
Recent illnesses:
Chronic medical conditions:
Allergies:
Current medications:
Previous surgeries or hospitalizations:
Dental history
Date of last dental visit:
Reason for last visit:

Previous and/or current dental issues:

History of dental surgeries:

Allergies (i.e. dental materials):

Dental habits:

Other relevant information:

Dental examination

Oral health assessment:

Gum health:

Presence of tooth decay:

Existing dental restorations:

X-rays (if applicable):

Additional information

Smoking habits (if applicable):

Alcohol consumption (if applicable):

Special instructions or considerations:

Dental clearance

Patient is: **cleared** **not cleared** for:

Recommendations:

Dentist's name:

Contact information:

Signature:

Date: