Dental Clearance Form

Patient Information

Full Name	
Date of Birth	
Gender	
Contact Number	
Address	
Emergency Contact	
Insurance Information	

Dental History:

Date of Last Dental Visit	
Reason for Last Visit	
Previous Dental Issues	
History of Dental Surgeries	
Allergies (Dental Materials)	

Medical History:

Current Medications	
Chronic Medical Conditions	
Allergies	
Recent Illnesses	
Hospitalizations	

Dental Examination:

X-rays (if applicable)	
Oral Health Assessment	
Gum Health	
Tooth Decay	
Existing Dental Restorations	

Additional Information:

Smoking Habits	
Alcohol Consumption	
Dental Habits	
Special Instructions or Considerations	

Dentist's Signature	
Date	