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: