Dental Medical Clearance Form

Patient Information

Name:	
Date of Birth:	
Phone Number:	Email Address:
Address:	

Emergency Contact

Name:
Relationship:
Contact Details:

Medical History

Do you have a history of any of the following medical conditions? (Check all that apply).

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Respiratory conditions (e.g., Asthma)
- ☐ Allergies (please specify): _____
- ☐ Bleeding disorders
- ☐ Infectious diseases
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Other (please specify): _____

Are you currently taking any medications? If yes, please list below:

Have you ever had a serious reaction to any medications or anesthesia? If yes, please explain:

Do you have any allergies to latex or other dental materials? If yes, please specify:

Have you ever had a serious reaction to any medications or anesthesia? If yes, please explain:

Have you ever been hospitalized or had surgery? If yes, please provide details:

Do you have a history of joint replacement or any prosthetic implants? If yes, please specify:

Are you pregnant or nursing? If yes, please inform the dentist before any X-rays or treatment.

- [ ] Yes
- [ ] No

Do you have any other medical conditions or concerns that the dentist should be aware of? If yes, please explain:

Dental Treatment Consent

I hereby authorize the dental team to perform the necessary dental procedures as discussed and agreed upon. I understand that during the course of treatment, unforeseen conditions may arise that necessitate additional procedures. I consent to the release of any information necessary for my dental care to other healthcare professionals.

Patient's Signature:

_____

Date:

_____

Dental Provider Information

Dentist's Name:
License Number:
Contact Number:
Email Address:

Dentist's Notes