Dental Medical Clearance Form

Patient information		
Name:	Gender:	
Date of birth:	Contact number:	
Address:		
Dental provider information		
Dental provider name:		
License number:		
Dental office name:	Office number:	
Office address:		
Medical provider information		
Referring physician name:		
License number:		
Office name:	Office phone number:	
Office address:		
Reason for medical clearance		
Procedure planned:		
Planned date of procedure:		
Reason for medical clearance:		
☐ Surgical procedure	□ Oral infection	
☐ Presence of coronary artery disease	☐ Chronic medical condition	
☐ Periodontal disease	☐ Other:	
Medical history		
Medical conditions:		
☐ Coronary artery disease	☐ Liver disease	
☐ Hypertension	☐ Respiratory disease	
☐ Diabetes mellitus	☐ Immunosuppression	
☐ Kidney disease	☐ Other:	

Medications currently taking:		
Allergies:		
Medical provider assessment		
Patient's current health status:		
Is the patient medically stable to undergo the	Are there any specific precautions or	
planned dental procedure?	modifications required for the planned dental procedure?	
☐ Yes	□ No	
□ No	☐ Yes (Please specify):	
Additional comments		
Physician's signature:	Date:	
Instructions for patient		
Please ensure that your medical provider completes this form and returns it to your dental office before your scheduled dental procedure.		