Nottingham Dental
WWW.NOTTINGHAMDENTAL.CA
664 WYE ROAD SUITE 330
SHERWOOD PARK AB T8A 6G3
OFFICE 780 467 2401
FAX 780 467 4362

Medical Clearance For Dental Treatment

Date:

Patient: ____________________________________ Birthday:________________

Dear Dr. ________________________

Our mutual patient, ________________________________is scheduled for dental treatment in our clinic.

Treatment may include:

Cleaning ___

Radiographs ___

Fillings, Crowns, Bridge ___

Extractions (Routine dental) ___

Surgical Extractions (more than average bleeding) ___

Root Canal Therapy ___

Nitrous Oxide ___

Local Anesthetic ___

Benzodiazepine for Sedation ___

Implants ___

RX ________

The patient has indicated the following medical conditions:

____

____

Please evaluate this patient's medical history and advise us of any special considerations that should be made.

Antibiotic Prophylaxis: Yes __ No __

Interruption of Anticoagulants Yes __ No__

Any Additional Comments: ____

Physician Name (Please Print) ____

Physician Signature: ____

We appreciate your assistance in providing optimum care for this patient.