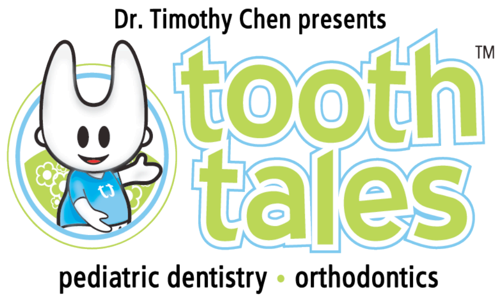

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every tiny tooth is precious :)

Medical Release Form

Patient's Name : ________________________________ **D.O.B.**____________________
(mm/dd/yyyy)

Dear Doctor,

Our patient's medical history includes the following conditions:

____

____

____

____

Prior to any dental treatment we require a medical clearance from the patient's physician.

Please answer the following questions as they apply to the patient.

Prophylactic antibiotic regimen needed prior to dental procedures:

____

Any pre or post-op medications required:

____

Any restrictions for the use of local anesthetics, conscious sedation medications and/or vasoconstrictors:

____

Any medications requiring our attention:

____

Additional comments or restrictions:

____

We follow this procedure in the patient's best interest. If you would like to discuss anything further please do not hesitate to call us. Dental treatment will not begin until we receive this medical clearance. Thank for your cooperation.

Doctor's Name: ____

Address: ____

____

City, State Zip ____