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COSMETIC, IMPLANT AND FAMILY DENTISTRY

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MEDICAL RELEASE FORM

DATE: _____ NO. OF PAGES: _____

TO: _____ FAX: _____

(Physician's name) (Physician's fax number)

RE: _____ DOB: _____

(Patient's name)

_____

(Patient Signature)

SUBJECT: Medical Clearance for Dental Treatment

Patient presents to our office with the following medical conditions which may warrant special considerations:

_____

_____

_____

The following treatment is required:

_____

_____

_____

IF prophylactic antibiotic treatment is required, I will follow the current ADA guidelines and prescribe the following protocol and prescription: _____

_____

_____

Instructions: Physician – Please complete section below, sign and fax back to our office. Thank you!

1. Is the patient healthy enough to undergo this treatment? (Please initial) YES _____ NO _____

2. Does the patient's medical condition require prophylactic antibiotic treatment?
(Please initial) YES _____ NO _____

3. If you recommend a different prophylactic treatment plan or antibiotic, please indicate below:

_____

_____

_____ _____

Physician's Signature Date