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Walnut Creek, CA 94598 (925) 939-3652

Request for Medical Clearance

To: Attending Physician Date: _____

RE: Request for Medical Clearance for

_____ _____
(Patient's Name) (Patient's D.O.B)

Please complete the following:

1. Does the patient have any known reactions to any of the following:
   a. Local anesthetic with epinephrine? ☐ Yes ☐ No ☐ Unknown
   b. Pain relievers? ☐ Yes ☐ No ☐ Unknown
   c. Antibiotics? ☐ Yes ☐ No ☐ Unknown
   d. Any other drug reactions? ☐ Yes ☐ No ☐ Unknown
   If yes to any of the above, please explain_____
   _____
2. Does this patient require a pre-medication? ☐ Yes ☐ No ☐ Unknown
   If so, what?_____
3. Does this patient have any medical conditions of limitations that I should be aware of?
   ☐ Yes ☐ No ☐ Unknown
   If so, please explain_____
4. Do you feel, at this time, that this patient is capable of undergoing the proposed dental treatment?
   ☐ Yes ☐ No ☐ Unknown
5. Date of patient's last physical exam. _____
6. Any suggestions or comments in regards to this patient?_____
   _____

The above named patient came into my office on_____ requesting dental treatment. Due to the health history given by this patient, I feel it is necessary to obtain a medical clearance from his/her attending physician in regards to the proposed dental treatment:

_____

_____

Thank you for your assistance. Please sign and date below, and return to the Preventive Dental Care Center office indicated below.

_____ _____
(Physicians Name) (Physicians Address)

_____ _____
(Physicians Signature) (Date)