In-House Dental Care

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MEDICAL CLEARANCE FORM (*CONFIDENTIAL*)

Referring Doctor: Dr. Richard A. Nguyen

☐ Urgent Matter / Return By: _____ ☐ Appt. Date: _____

Date _____

To: _____ (O) _____ (F) _____
(Physician's Name)

Re: _____ (DOB) _____ Contact Person: _____
(Patient's Name)

Contact Number: _____

X. _____
Patient's Signature/ Responsible Party authorizing exchange of information between dentist and physician

INSTRUCTIONS: Physician – Please complete Section 2, sign and fax / email back to Dentist.

SECTION 1

To be completed by the dentist

1. *Dental Treatment Plan:* _____
2. *Patient's condition which may warrant special considerations:* _____

_____

SECTION 2

To be completed by the physician

1. *Is Patient taking or have ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, or Skelide)?*

   (Please Initial) *Yes* _____ *No* _____

2. *Is Patient Healthy Enough to undergo this treatment?* *(Please Initial)* *Yes* _____ *No* _____

3. *Does the patient's medical condition require prophylactic antibiotic treatment?*

   (Please Initial) *Yes* _____ *No* _____

4. *What choice and dosage of Prophylactic Antibiotics that you would like to prescribe to the patient?*

   _____

5. *Can patient stop blood thinners medication prior to dental treatments?* *Yes* _____ *No* _____

   If so, how many days should patient STOP prior to dental treatment? _____

   And when should patient go back to blood thinners after dental treatment? _____

_____ _____
Dentist's Signature Date

_____ _____
Physician's Signature Date