UNIVERSITY OF CALIFORNIA, SAN DIEGO **UCSD**

BERKELEY DAVIS IRVINE LOS ANGELES RIVERSIDE SAN DIEGO SAN FRANCISCO

SANTA BARBARA SANTA CRUZ

Student –Run Free Clinic
Department of Family and Preventive Medicine
School of Medicine

9500 Gilman Drive #0696
La Jolla, CA 92093-0696

Medical Clearance for Dental Treatment

Date:

Attn:

Patient: _____ Birthdate: _____/_____/_____ (mm/dd/yy)

Dear Dr.

Our mutual patient is scheduled for dental treatment.

Treatment may include:

- ☐ Cleaning (simple or deep)
- ☐ Radiographs
- ☐ Fillings, Crowns, Bridges
- ☐ Extractions (simple or surgical)
- ☐ Root Canal Therapy
- ☐ Nitrous Oxide
- ☐ Local anesthetic (with epinephrine)
- ☐ Other: _____

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
How long before and after treatment: _____
Anesthetic restrictions: ☐ Yes ☐ No
Is Epinephrine OK? ☐ Yes ☐ No
Type of antibiotic allowed / recommended: _____
Type of pain medication allowed / recommended: _____
Any additional comments:

Physician Name (please print): _____

Physician Signature: _____ Date: _____/_____/_____ (mm/dd/yy)

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

For the intended patient: Please have physician sign and bring form back to dental clinic.