GOLDEN COAST
DENTAL CARE

MEDICAL CLEARANCE

Date: _____

To:

Dr. _____

Address: _____

City/State/ Zip: _____

Fax: _____

Dear Dr.

We recently examined our mutual patient _____ , date of birth _____ , and have determined that the patient needs dental treatment including the following procedure(s): _____

_____

_____

The patient will receive the following local anesthetic:

_____ Lidocaine 2% with 1:100,000 epi

_____ Carbocaine- no epi

_____ Articanine4% with 1:100,000 epi

We are seeking medical clearance for the patient to receive the recommended dental treatment and request your response to the following:

Is it, in your opinion, medically safe for the patient to receive the recommended dental services at this time?

Yes No

Does the patient's medical condition/history require the use of pre-medication for dental procedures?

Yes No

If yes, please provide us with the recommended medication and administration instructions: _____

_____

Please return a completed copy of this form to our office via fax at (562) 421-8401.

_____ _____

PHYSICIAN'S SIGNATURE PHYSICIAN'S PRINTED NAME

_____ _____

DENTIST'S SIGNATURE DENTIST'S PRINTED NAME

GOLDEN COAST
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PATIENT'S CONSENT FOR RELEASE OF MEDICAL CLEARANCE INFORMATION

I _____ , am a patient at Golden Coast Dental Care. I recently had condition(s) and/or history relevant to the treatment recommended.

_____ _____

PATIENT'S SIGNATURE PATIENT'S PRINTED NAME