SLEEPY HOLLOW DENTAL ARTS P.C.
358 N. Broadway, Ste.201   Sleepy Hollow, NY 10591
TEL: (914)- 332-5100   FAX: (914)-332-5108

Medical Clearance for Dental Treatment

Date:____________________
Attn:____________________
Patient:______________________________   DOB: _______________
Dear Dr. ______________________________

Our mutual patient, _____________________________________ is scheduled for dental treatment.

Treatment may include:

___ Cleaning (simple or deep)
___ Radiographs
___ Fillings, Crowns, Bridges
___ Extraction (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: __________________________

Any additional comments?
____
____
____

Physician (please print) ____
Physician Signature ____

We appreciate your assistance in providing optimum care for this patient.
Please have physician sign and fax to above.