Medical Clearance for Dental Treatment

Dear primary physician,

Our mutual patient, , is planning on having dental procedure.

Potential intra-operative medications include :

Potential post-operative medications include :

Please, evaluate his/her medical condition and report back to us, in writing, with the following information:

TO BE COMPLETED BY THE PHYSICIAN

Date of Report :

Reporting Physician's Information :

Name :

Address :

Phone No. :

1. List of all current medications :

2. List of known medical conditions :

3. List of known drug allegies :

4. Are there any special precautions of contraindications to the proposed treatment?
(Please, be as specific as possible.)

5. Do you feel this patient can be safely treated in the dental office setting? (Yes / No)

Signature of Physician

As the reporting physician, please either use this form of send your own information. For your convinience, you may fax your reponse to 832.243.6787

If you have any questions regarding the above, please call to office to speak with dentsit at 832.243.6787

Thank you.

Sincelely,

, D.D.S.

Date :

Leo Dentistry
5607 G Uvalde Rd, Huston, TX 77049
Tel. 832.230.3122 Fax. 832.598.2317