ARTISTICDENTAL
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BEAUTIFUL SMILES THROUGH EXCEPTIONAL DENTISTRY

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OB CLEARANCE FOR DENTAL PROCEDURE

Date of Request_____

Dear Dr. _____,

Our mutual patient, _____, may require emergency/or routine dental care. Please fill out this clearance form and fax back as soon as possible.

The patient reports the following medical conditions: _____

_____

The following medications: _____

The following known allergies : _____

Other findings or concerns: _____

_____

*** TO BE COMPLETED BY PHYSICIAN***

Patient is _____ weeks pregnant.

Are there any special precautions or contraindications to dental treatment with local Anesthetic or any necessary x-rays?

_____

Which antibiotic do you recommend? _____

Which local anesthesia would you recommend? 2% Lidocaine with 1:100,000 epi or 3% Carbocaine plain

Do you feel this patient can be safely treated in the dental office setting at this time? Yes or No

Physician's Signature_____ Date _____

Physician's Name (printed) _____Phone Number _____