WellCare
Beyond Healthcare. A Better You.

Medical Clearance Form for Dental Treatment

To Dr.:_____ From:_____

Please Return By:_____ Dentist Signature:

Pertinent Medical History:

_____

_____

Reason for Request:

The patient listed above is a registered patient at our office. <She> will receive dental care that may include extractions, endodontics, and deep cleanings under local anesthesia with epinephrine.

X:_____

Patient Signature for Authorization of Medical Consult

PLEASE ADVISE THE FOLLOWING ITEMS AND CIRCLE:

1. What is the patient's general medical status? ☐ Excellent ☐ Fair ☐ Poor

2. ☐Yes ☐No Does this patient take any medications that must be discontinued or where the dose must be changed prior to dental treatment? (i.e. blood thinners, steroids, immunosuppresents, bisphosphonates, etc.)

   If Yes, which and for how long?

   _____

   _____

3. ☐Yes ☐No Are there any medical contraindications or recommendations with the anticipated dental treatment?

   If Yes, please describe:

   _____

   _____

4. ☐Yes ☐No Does this patient have a need for antibiotic prophylaxes prior to dental treatment?

   If Yes, which: _____

   _____

☐ **PATIENT CLEARED FOR DENTAL TREATMENT** ☐ **PATIENT NOT CLEARED FOR DENTAL TREATMENT**

Physician Signature_____ **Physician Name:**_____

Address: _____ **Phone:**_____

_____ **Fax:** _____

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