SAMPLE

MEDICAL CLEARANCE FOR DENTAL PROCEDURE

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Patient **Date**

Age:______ VS:____________________________Ht:________Wt:________

Allergies: ____

Past Illnesses/
Injuries:____

Medical
Conditions:____

Medications:____

____

Anticoagulation Therapy Recommendations:

____

Findings:

____

____

____

I certify that on this date I examined ________________________________ at
(Name of Patient)
his/her request and the request of ___________________________________.
(Name of Dentist)

On the basis of my examination, together with the medical history furnished by the patient, I have found no indications of a physical or medical condition that would prevent this patient from undergoing the proposed dental procedure.

Proposed Dental
Procedure(s):____

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Physician's Signature Date