SEABLUE DENTAL

23914 100th Ave SE, Kent WA
(253) 336-3000 (253) 336-3050
info@seabluedental.com
www.seabluedental.com

MEDICAL CLEARANCE FOR DENTAL TREATMENT

Date: ______________________ Attention: ______________________

Patient Name: ______________________ Date of Birth: ______________________

Our mutual patient, as noted above, is scheduled for dental treatment at our office. Treatment may include:

- ☐ Cleaning (simple or deep)
- ☐ Radiographs (x-rays)
- ☐ 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:

____

____

Patient Name (Please Print) ______________ Patient Signature ______________ Date ______________

Dentist Comments:

____

____

Dentist Name (Please Print) ______________ Dentist Signature ______________ Date ______________

Physicians: Please complete the section below.

Evaluate this patient's medical history and advise us of any special considerations that should be made.

Does the patient require antibiotic prophylaxis? ☐ Yes ☐ No

Reason for prophylaxis: ______________________

Does the patient require an interruption of anticoagulant treatment? ☐ Yes ☐ No

How long before and after treatment? ______________________

Are there any restrictions anesthetic for this patient? ☐ Yes ☐ No

Is the use of epinephrine okay? ☐ Yes ☐ No

Type of antibiotic that is allowed/recommended for patient: ______________________

Type of pain medication that is allowed/recommended for patient: ______________________

Additional comments:

____

____

Physician Name (Please Print) ______________ Physician Signature ______________ Date ______________

We appreciate your assistance in providing optimum care for this patient.
Please have the **physician** sign and fax this form to Seablue Dental at (253) 336-3050.