NORTH ISLAND DENTAL ARTS
1613 Hillside Avenue, New Hyde Park, NY 11040
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•phone: 516-616-4800 •fax: 315-825-4788•

Medical Clearance for Dental Treatment
Date:
Attn:
Patient:

Dear Dr,

Our Mutual patient, _____ is schedule for dental treatment.

Treatment may include:

__ Cleaning (Simple & Deep) Bleeding Anticipated
__ Radiographs
__ Fillings, Crown(s), Bridge(s)
__ Extraction (Simple & Surgical)
__Root Canal Therapy
__ Nitrous Oxide
__ Local Anesthetic (With epinephrine)

The patient has indicated the following medical history and advise us of any special considerations that should be made. All Please Complete Questions.

1. Antibiotic Prophylaxis Yes__ No__
2. Interruption of Anticoagulants: Yes__ No __
A. How long before and after treatment? ___
3. Anesthetic Restrictions: Yes__ No__
4. Type of antibiotic allowed/ recommended:
5. Type of pain medication allowed/ recommended:
6. Any additional comments: _____

Physician Name (Please print):_____
Physician Signature: _____
Date: _____

We appreciate your assistance in providing optimum care for this patient. Please have physician sign and fax to (315-825-4788) or email us at office@northislanddental.com.