North Island Dental Arts
1613 Hillside Ave
New Hyde Park, NY 11040

Medical Clearance for Dental Treatment

Date:
Attn:
Patient: Birthdate:

Dear Dr.

Our mutual patient,_____is schedule for dental treatment.

__ Cleaning (Simple & Deep), Bleeding Anticipated
__ Radiographs
__Fillings, Crown, Bridges
__Extraction (Simple & Surgical)
__ Root Canal Therapy
__ Nitrous Oxide
__ Local Anesthetic (with Epinephrine)

__ Other_____

Please evaluate this medical history and advise us of any special considerations that should be made.
Please Complete All Questions.

1. Antibiotic Prophylaxis: Yes__ No__
2. Interruption of Anticoagulants: Yes__ No__
3. CBL (INT/PT levels? _____
4. Anesthetic Restrictions: Yes__ No__ (If yes Specify restrictions_____)
5. Is Epinephrine Okay? Yes__ No__
6. Type of antibiotic allowed/ recommended:
7. Type of pain medication allowed/ recommended:___
8. Type of pain medication allowed/ recommended:___
9. 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:

1613 Hillside Ave. New Hyde Park, NY 11040
516-616-4800 Tel} 516-616-0364 Fax
northislanddental@yahoo.com