Dentistry on Kennedy

Dr. Ellen R. Felaire
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Date: _____

To: Dr. _____ Phone: _____
Fax: _____

RE: REQUEST FOR MEDICAL CLEARANCE

Name of Patient: _____

I have examined the patient and recommended the following dental treatment in my office:
□Tooth extraction □ Root Canal □Fillings □Prophylaxis

Based on the medical information given to us by the above patient, it is noted that the patient was previously, or presently under your care for an existing medical condition as reported by her/him.
(_____).
(Brief description of medical condition as reported by patient)

In order for us to deliver safe and efficient dental treatment while being aware of patient's medical condition, I would like to request a brief written medical clearance to ensure that any of the above proposed treatment is permissible. Specifically, the above procedures may need local anesthetic (2% lidocaine with epinephrine) and analgesic for post operative pain.

In your opinion, is there any contraindication to any of the proposed dental treatment? Finally, are there any other medical considerations of which I should be aware that the patient might not have fully disclosed to me?

If you have any questions or concerns, please do not hesitate to give me a call. Your cooperation is greatly appreciated.

Thank you,

Ellen R. Felaire, DDS

Medical Doctor's Brief Notes/Recommendations:

_____
_____
_____

Doctor's Signature: _____ Date: _____

Patient's Consent to Authorize the Release of Medical Information

I hereby authorize the release my medical records as requested above:

Patient's Signature: _____ Date:__ _____