KAISER & ROSEN DENTAL ASSOCIATES

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Philadelphia, PA 19115
(215) 464-5600
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PHYSICIAN CLEARANCE FOR DENTAL TREATMENT

Dear Doctor,

___________________________________was seen by our dental service and the following was noted:____.
Our proposed treatment plan for this patient includes:____
____.

In view of this patient's medical history, and in order that our mutual patient receive optimal healthcare, would you please respond to the question(s) below. This patient cannot be scheduled for further care until we receive this form from your office. Thank you in advance for your help and cooperation. Sincerely,

____DDS / DMD
Dental Service Provider

1) (a) Should this patient be premedicated with an antibiotic if at risk for Bacterial Endocarditis? YES ( ) NO ( )
(b) If so, current American Heart Association regimen?) YES ( ) NO( )

(c) If "YES" , please indicate the condition necessitating premedication:
( ) Vegetative Heart Murmur ( ) History of Rheumatic Fever ( ) Artificial Heart Valve
( ) Recent Heart attack ( ) Recent Cardiac Surgery ( ) Pacemaker
( ) Mitral Valve Prolapse ( ) Vascular Surgery ( )Prosthetic Devices
( ) Other:____

2) Are there any Contraindications to the use of:
(a) Local Infiltration Anesthesia (Lidocaine 2%) Yes ( ) No( )
(b) Epinephrine 1:100,000 (0.01mg/ml) Yes ( ) No( )
(c) Dental Radiographs Yes ( ) No( )

3) Does this patient need to have medication levels modified prior to dental treatment?
(ie: Anticoagulant therapy) YES______ NO______

4) Patient's current medical condition (ie: Is this patient medically stable?)
____
____

5) Current medications (please include dosage and frequency):____________________
____
____

6) Contraindications or recommendations prior to dental treatment:_________________
____

7) Do you feel further consultation is necessary? Yes ( ) No ( )

Physician's Name:______________________________________Date:_________________________
Office Address:_______________________________ Office Phone: (______)______-______________

Physician's Signature:____
(**Please instruct patient to return this form to the dental office prior to treatment or please mail this to the above address. Thank you for your time and cooperation.)