from the desk of

NINA KUMAR, DDS

medical clearance

address
405 Lexington Ave
Tower Suites 6900
New York, NY 10174

tel 212-867-2967
fax 212-697-0677

PATIENT NAME: ______________________________

DOB: ____ / _____ /______

Pt reports the following medical history:

____

____

____

Patient reports taking the following medications:

____

____

____

Pt requires extensive dental treatment. Please clear patient for dental treatment and provide any recommendations for treatment.

*****TO BE COMPLETED BY THE PHYSICIAN*****

Name of reporting Physician: ______________________________

Address of reporting Physician: ______________________________

Phone # of reporting Physician: ______________________________

Date of last exam:

1. Verify list of all current medications:

____

____

2. Verify all known medical conditions:

____

____

3. List of known drug allergies: ______________________________
4. Are there any special precautions &/or contra-indications to dental treatment?
   Yes ☐ No ☐ if so, please specify: ______________________________
5. Antibiotic prophylaxis: Yes ☐ No ☐
6. Is there a need for interruption of medications?:
   Yes ☐ No ☐ if so, please specify: ______________________________
7. Anesthetic restrictions:
   Yes ☐ No ☐ if so, please specify: ______________________________
   →Is Epinephrine OK? Yes ☐ No ☐
8. Any additional comments:

____

____

____

____

Physician Signature ______________________________

Date: ____ / _____ /______