Medical Clearance Form – Existing Patients

FEBRES DENTISTRY FOR CHILDREN

2000 S. Dairy Ashford Rd. Suite 530. Houston, TX 77077

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To: ____ Date: ________________

Phone: ____________________ Fax: _________________

Patient's Name: ______________________________ DOB: ________________

Our above named mutual patient is in need of:

A. ☐ Dental Cleaning

B. ☐ Restorative treatment under the use of:

   a. ☐ Nitrous oxide

   b. ☐ Oral sedation (any combination of Demerol, Vistaril, Versed, Valium)

   c. ☐ Ketamine / IV sedation / General Anesthesia

However, before we can schedule his/her appointment, we kindly request a medical clearance from your office. Please provide the information below (fill in the applicable boxes), sign, date and fax to our office at 281- 598 0194. Thank you for your time and attention to this matter.

1. ☐ Does require pre-medication. Please indicate type of medication.

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2. ☐ Does not require pre-medication.
3. Are there any special precautions or contraindication to dental treatment?

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4. ☐ Medical Clearance Granted.

X____ Date: ___________

Signed by physician