Medical Clearance Form – New patients

FEBRES DENTISTRY FOR CHILDREN

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Patient's Name: ______________________________ DOB: ________________

Your patient has contacted our office seeking dental care. We have noticed from medical history that the patient has a medical condition that requires your approval before any medications can be administered. Please respond to the following questionnaire and have it returned to our office as soon as possible so that we can proceed.

TREATMENT PROPOSED:

____

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ANTIBIOTIC OF CHOICE: ____

ANALGESIC OF CHOICE: ____

Would you recommend prophylactic antibiotic coverage for sub-acute bacterial endocarditis?

☐ Yes ☐ No

ANTIBIOTIC PREFERRED: ____

Any contraindication for the use of Demerol & Phenergan, or Midazolam oral sedation?

☐ Yes ☐ No

Physician name: ____ Date: ___________

X____

Signed by physician