Smiles of Northshore

5626 E. Sam Houston Parkway North Houston, TX 77015 Tel. 281-452-7900 Fax 833-790-4669

Medical Clearance Record

To Doctor_____

Clinic _____

Phone_____ Fax _____

Our Mutual Patient _____ D.O.B. _____
Has noted the following conditions(s) in a routine health history:
_____ Heart Murmur _____ Rheumatic Fever _____ Pacemaker

_____ Artificial Joints, Pins Screws or Heart Valves _____ Synthetic Hernia Repair _____ Taken Fen-Phen, Piondimin or Redux

_____ Bleeding Disorder or Taking Blood Thinners

_____ Other _____
Treatment recommended: _____

Does this patient require prophylactic Antibiotic Coverage prior to dental treatment? Yes or No

1. If yes, please state reason _____
   Oral regimen you recommend:
   RX ___ Amoxicillin ___ Clindamycin ___ Keflex ___ Zithromax ___ Biaxin

2. Please recommend the following local anesthetic:
   _____ 2% lidocaine 1:100,000 with EPI
   _____ Mepivacaine without EPI
   _____ Other please specify _____

3. Medication Allergies _____

4. Please print a brief description of the patients' condition and any additional precautions that you feel are beneficial:

_____
_____
_____

Please fax this letter back to us. We must have this clearance form completed and signed before providing treatment. Thank you.

Physicians Name _____

Physicians Signature _____