THOMPSON SMILES
Dr. Sonalika Rungta, DMD
520 Riverside Drive , PO BOX 5
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860-923-2202
Comfortable Dentistry, with a Gentle Touch

MEDICAL CLEARANCE FOR DENTAL TREATMENT

Patient Name: _____ DOB: _____

Dear Dr. _____,

Our mutual patient, _____, is scheduled for dental treatment.

Treatment may include, but is not limited to:

_____ Prophylaxis (Cleaning- simple or deep) _____ Radiographs

_____ Restorations _____ Local Anesthetic (with epinephrine)

_____ Dental Crown(s) or Bridge _____ Root Canal Therapy

_____ Extractions (simple or surgical) _____ Other: _____

The patient has indicated the following medical conditions: _____

_____

Please evaluate this patient's medical history and advise us of any special considerations that should be made.

Antibiotic prophylaxis: ❑ Yes ❑No

Interruption of anticoagulants: ❑ Yes ❑No

How long before and after treatment: _____

Anesthetic restrictions: ❑ Yes ❑No

Is Epinephrine OK? ❑ Yes ❑No

Type of antibiotic allowed/recommended: _____

Type of pain mediation allowed/recommended: _____

Any additional comments: _____

_____

Physician Signature: _____ **Date**: _____

We appreciate your assistance in providing optimum care for our patient.

Please complete form, sign and return to:
office@thompson-smiles.com
-or-
fax: 860-362-9956