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REQUEST FOR MEDICAL CLEARANCE

Date:_____

Regarding Patient: _____ D.O.B._____

Dear Doctor: _____ The above named patient had indicated that you are his/her physician. The patient has indicated a medical history of the following:

_____
_____
_____
_____

- This patient may require the following dental procedures:
- EXTRACTIONS
- PERIODONTAL TREATMENT
- ENDODONTIC THERAPY
- RESTORATIVE WORK
- OTHER

_____
_____
_____
_____

Thank you _____

Physician's Response:

_____
_____
_____
_____

Physician's Printed Name and Signature Please:_____

I hereby authorize the release of the above requested information and understand this information will be held in confidence by both physician and the dentist.

Patient Signature:_____