Grass Valley Periodontics
316 S Auburn St, #7
Grass Valley, CA 95821
Phone: 530-273-3312 Fax: 530-273-2932

Date: _____
To: Dr. _____ M.D.
Fax: _____
Phone: _____

Re: Medical Clearance for Patient Treatment

Patient: _____ DOB: _____ Age: _____

Scheduled Appointment: _____

Proposed Procedure: _____

Dear Doctor _____

I am requesting the following information in my attempt to provide the best care for our mutual patient.

Pertinent past Medical History:

Are there any known Allergies or Drug Intolerances?
Yes_____ No_____

If yes, please list medications: _____

Medical Conditions:

____Cardiovascular
____Pulmonary
____Hemotopoietic
____Infectious Disease
____Endocrine
____Neuropsychiatric
____Hepatic
____Renal
____Autoimmune
____Hypertension
____Muscoloskeletal
____Substance Abuse

Do you suggest pre-medication with antibiotics?
Yes_____ No_____
Which dosage and timing would you suggest?

What are the indications for the pre-medication?

Local anesthesia is an essential part of the treatment; would you suggest we do not use any agents that contain Epinephrine?

Considering the above mentioned information, are there any relative or strict contraindications to the planned treatment?
Yes_____ No_____

If yes please explain_____

Please indicate your concerns and recommendations and fax your response to this request.

Thank you for your guidance in the management of our mutual patient's treatment.
Any questions please do not hesitate to contact me.

_____

_____
Dr. Navneet Arora, D.D.S