Dental Clearance Form

PATIENT INFORMATION

Full name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____

Contact information (email and/or number):

Address:

Emergency contact (name and contact information):

Insurance information:

MEDICAL HISTORY

Recent illnesses:

Chronic medical conditions:

Allergies:

Current medications:

Previous surgeries or hospitalizations:

DENTAL HISTORY

Date of last dental visit: _____ dd / mm / yyyy

Reason for last visit:

Previous and/or current dental issues:

History of dental surgeries:

Allergies (i.e. dental materials):

Dental habits:

Other relevant information:

DENTAL EXAMINATION

Oral health assessment:

Gum health:

Presence of tooth decay:

Existing dental restorations:

X-rays (if applicable):

ADDITIONAL INFORMATION

Smoking habits (if applicable):

Alcohol consumption (if applicable):

Special instructions or considerations:

DENTAL CLEARANCE

Patient is: _____

If not cleared, specify reason below.

Recommendations:

Dentist's name: _____ Contact information: _____

Date: _____ dd / mm / yyyy

Signature: