EMERGENCY MEDICAL CLEARANCE FORM

RELEASE OF RECORDS CONSENT

I,_____, hereby consent to the release of my medical records or any information
Patient Name

regarding my health status to _____
Dental Provider Office

_____ _____
Patient Signature Date

MEDICAL CLEARANCE REQUEST

Patient Name: _____ DOB: _____ Date: _____

Expected Due Date: _____ Week of Gestation: _____ Allergies: _____

Pregnancy/Medical History: _____

This patient has presented to our clinic for dental treatment. The following is standard protocol for our treatment of pregnant dental patients:

Necessary radiographs will be taken with lead shielding of the abdomen and the thyroid area

- Treatment may include any of the following:
  - Dental prophylaxis
  - Scaling and/or root planning
  - Root canal therapy
  - Fillings
  - Extractions
  - Crowns
  - Topical Fluoride /Topical Fluoride Varnish 5% NaF
- If local anesthetic is used, 2% Lidocaine with epinephrine 1:100,000 is used most often
- For non-narcotic pain management, OTC Acetaminophen will be recommended
- If antibiotic is needed, either Amoxicillin or Clindamycin will be prescribed
- *According to the National Maternal and Child Oral Health Consensus Statement "oral health care, including the use of x-rays, pain medication and local anesthesia is safe throughout pregnancy", 2012; http://www.mchoralhealth.org*

_____ _____
Signature Dental Provider Email Address

MEDICAL CLEARANCE

Please sign below for medical clearance or indicate further guidance for dental treatment:

I agree with above protocol: _____ _____
Physician Signature Date

I disagree with the above mentioned protocol and would like to provide additional guidance:

_____

_____

_____ _____
Physician Signature Date

Please return to:

_____ _____ _____
Dental Provider Office Telephone Number Fax Number

_____ _____
Address City/State/Zip code