

Dental Clearance Form

Patient information

Full name:

Date of birth:

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:

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: cleared not cleared for:

Recommendations:

Dentist's name:

Contact information:

Signature:

Date: