



the ENDODONTIC GROUP

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Medical Clearance for Surgical and/or Non-Surgical Endodontic Treatment

Patient: _____

Date: _____

The above patient is scheduled for endodontic treatment. The outpatient treatment or surgery will be performed in my office under local anesthesia. Planned Treatment: _____
The following information has been provided by the patient.

Medical History: _____

Allergies to Medications: _____

Current Medications: _____

The following medications may be prescribed for endodontic surgical or non-surgical treatment:

Antimicrobials

Sedation Meds

Anti-Inflammatory

Analgesics

(If needed)

___ Amoxicillin

___ Valium

___ Ibuprofen

___ Hydrocodone

___ Clindamycin

___ Triazolam

___ Dexamethasone

___ Codeine

___ Augmentin

___ Ativan

___ Naproxen Sodium

___ Percocet

___ Azthromycin

___ N2O Gas

___ Ultram

Request for Medical Cleanance: _____

PLEASE PROVIDE ANSWERS TO THE FOLLOWING QUESTIONS:

- Date of most recent physical exam: _____
- Significant medical conditions, treatments, diseases, injury or comments:

- The patient is an acceptable candidate for outpatient dental treatment _____ YES _____ NO
- Any recommended medication adjustments prior to procedure _____ YES _____ NO
- Please contact me prior to treating this patient: _____ YES _____ NO
- Patients latest INR: _____ Date: _____

Signature of Physician

Date

Please Fax back to the office at either (508) 620-9261 or (508) 473-1298

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