Smiles of Carpentersville
27 S Western Ave, Suite E, Carpentersville, IL 60110
Ph. 847-783-6544
Email: pallamdentalclinic.soc@gmail.com

Consultation Request/Medical Clearance For Dental Services

Dear Dr, Date: _____

RE:
Patient: _____
DOB: _____

In an attempt to provide the best and safest dental care for our mutual patient, we are requesting a medical consultation and authorization for dental care in our office which may include the following:
_____
_____
_____

The patient has indicated the following medical conditions:
_____
_____

ANTIBIOTIC PROPHYLAXIS: YES / NO
TYPE OF ANTIBIOTIC: _____

LOCAL ANESTHETIC RESTRICTIONS: YES / NO
IF YES, PLEASE SPECIFY: _____

OTHER PRECAUTIONS/ADDITIONAL COMMENTS:
_____
_____

_____
Physician Signature