Dental Treatment Clearance Form

Dr. Kathryn E. Smith Zimmerman DDS/Dr. Jerry W. Reeves DDS has _______________________________, DOB____/____/_______, scheduled for dental treatment. We need pre-operative clearance for dental treatment. Please have your doctor return this to us by fax (336)299-9176.

*****TO BE COMPLETED BY PHYSICIANS OFFICE*****

I have examined ________________________ on__________. I feel there are no contraindications to the upcoming dental treatment.

⬜ Patient is released for treatment, but antibiotics are required prior to treatment. The following regimen is recommended:

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⬜ Patient is released for treatment and no antibiotics are required prior to treatment.

Print or Stamp Physician's Name: _______________________________

Address: ____

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Phone: ____________________

Fax: ______________________