# Medical Release for Dental Treatment

Patient's Name _____ Date of Future Treatment _____

Dental Office _____ Phone Number _____

I examined your patient _____ on _____ and recommended the following dental treatment _____

_____

Before proceeding, we want to ensure the patient can be treated safely. Your patient indicated that he/she has the following medical conditions _____

_____

and/or is taking the following medication(s) _____

_____

In your opinion, are there any contraindications in performing the needed dental treatment?

_____

_____

Do you recommend pre-medication? Yes No Type _____

Medications recommended for pain and/or infection for this patient _____

_____

Other recommendations or instructions _____

_____

_____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Physician's Signature** | Phone Number | Fax Number | Date |

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **D.D.S./Specialist Signature** | Phone Number | Fax Number | Date |

I hereby authorize my Physician to release any pertinent facts regarding my medical condition to the above named dentist/specialist.

_____

**Patient's Signature**