Hidy Stavarache, D.D.S.
Family and Cosmetic Dentistry

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(702) 233-8371 Fax (702) 233-8692

Medical Clearance Record

Doctor: _____ Contact person: _____

Clinic: _____ Phone: _____ Fax: _____

Address: _____ _____

Our mutual patient _____, DOB _____

Has noted the following conditions(s) in a routine health history:

- ☐ Heart Murmur / MVP
- ☐ Artificial Joints, Pins Screws or Heart Valves
- ☐ Other _____
- ☐ Rheumatic Fever
- ☐ Synthetic Hernia Repair
- ☐ Bleeding Disorders or Taking Blood Thinner
- ☐ Pacemaker
- ☐ Taken Fen-Phen, Pondimin or Redux

→1. Does the patient require Prophylactic Antibiotic Coverage prior to dental treatment? ☐ Yes ☐ No

If yes, for how long? 6 months 1 year 2 years 3 years other: _____

If no, please state reason: _____

Oral Regimen you recommend:

RX: ☐ Amoxicillin ☐ Clindamycin ☐ Keflex ☐ Zithromax ☐ Biaxin

DISP:

SIG:

→2. Are there any contradictions to the use of:

Local Anesthesia ☐ Yes ☐ No

Local Anesthesia with the vasoconstrictor epinephrine ☐ Yes ☐ No

→3. Medication Allergies: _____

→4. Please print a brief description of this patient's condition and any additional precautions that you feel are necessary or beneficial: _____

_____

Please fax this letter back to us. We must have this document completed and signed before providing treatment. Thank you.

Physician's Signature _____ Date _____

Physician's Name _____
(Please Print)

PATIENT'S AUTHORIZATION

I voluntarily give my authorization to use or disclose my protected health information regarding the above named condition(s) to: Dr. Hidy Stavarache of **Hidy Stavarache, D.D.S., Ltd.** I hereby authorize Hidy Stavarache, D.D.S., Ltd. to receive and use my protected medical information for the purpose of documenting any and all medical clearance required prior to dental treatment. This authorization will end on the following date: _____ or when dental treatment is completed. I understand that I may revoke this authorization at any time. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. I agree with all statements made in this authorization. I understand that, by signing this form. I am confirming my authorization for use and disclosure of the protected health information described in this form with the people and / or organizations named in this form.

_____ _____
Patient, Guardian or Representative Signature — Date

_____ _____
Patient, Guardian or Representative Printed Name — Relationship