



**JON C. GREENE**  
DDS • PA

## Physician Report and Medical Clearance for Dental Surgery

Dear \_\_\_\_\_, M.D.:

Date of Request: \_\_\_\_\_

Our mutual patient, \_\_\_\_\_, is planning on having dental surgery with local anesthesia and possibly IV conscious sedation. **Potential intra-operative medications include:** Valium, Versed, Fentanyl, Phenergan, Dexamethasone, Lidocaine with Epinephrine, Marcaine with epinephrine, and Nitrous Oxide. **Potential post-operative medications include:** Lortab, Penicillin, Phenergan, Peridex, Cleocin, Ibuprofen, and Tylenol. Please evaluate his/her medical condition and report back to us, in writing, with the following information:

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\* TO BE COMPLETED BY THE PHYSICIAN \*\*\***

Name of Reporting Physician: \_\_\_\_\_ Date of Report: \_\_\_\_\_

Address of Reporting Physician: \_\_\_\_\_

Phone No. of Reporting Physician: ( \_\_\_\_\_ ) \_\_\_\_\_

1. List of all current medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. List of known medical conditions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. List of known drug allergies: \_\_\_\_\_

4. Are there any special precautions or contraindications to the proposed treatment? *(Please be as specific as possible.)*

\_\_\_\_\_  
\_\_\_\_\_

5. Do you feel this patient can be safely treated in the dental office setting?      Yes    or    No      *(please circle one)*

\_\_\_\_\_  
Signature of Physician

As the reporting physician, please either use this form or send your own information. For your convenience, you may scan and email your response to [jon@jgreenedds.com](mailto:jon@jgreenedds.com). If you have any questions regarding the above, please call Dr. Greene at 210.860.2217. Thank you.

Sincerely,

Jon C. Greene, DDS, PA working with \_\_\_\_\_, D.D.S.

**Jon C. Greene, DDS, PA ■ Virtual Innovative Practice Systems**

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