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DENTAL CLEARANCE LETTER

Patient _____ DOB _____

The patient above has been ordered to receive medical treatment at our clinic. A bisphosphonate treatment is awaiting dental clearance from you.

The treatment that has been ordered is _____

Please review this patient's current dental health and fill out this form request and return to us via fax.

Date of last dental exam_____

☐ Patient is cleared to receive the treatment listed above

☐ Patient is NOT cleared to receive the treatment listed above

Dentist name (PRINT) _____

Dentist signature _____

Dental Practice_____

Date _____

PLEASE FAX THIS LETTER TO 704-377-0353

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