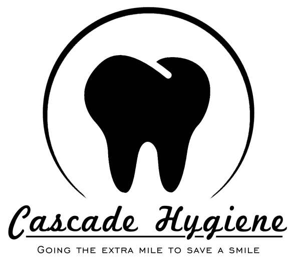

Medical Clearance Request
For Routine Dental Care

Physician Information

Phone ______________________________

Name ______________________________ Fax ______________________________

Street ____________________ City ____________________ State ______ Zip __________

Patient Information

Name ______________________________ DOB __________ Residing at ____________________

The above listed patient may have oral hygiene services, including oral screening, oral prophylaxis, periodontal screening, non-surgical periodontal procedures, Chlorhexadine, irrigation and fluoride treatments by any employee of Cascade Hygiene LLC, PRN at the patient's residence due to the patient's disability or inability to travel and be treated in a traditional dental office. Treatment may be made in conjunction with an annual visit to their dentist.

Physician's signature ______________________________ **Date** ______________

License #______________________________ **DEA #** ______________________________

1. Does this patient have any medical history concerns that would require pre-medication therapy prior to a routine dental cleaning?

   ☐ NO
   ☐ Yes

   Please list medical history concerns below:

   ____

   Medication(s): ____

   *** Please call in prescriptions to the patient's pharmacy so they can continue with dental care ***

2. If the patient is on an anticoagulant, should this medication be stopped prior to treatment?

   ☐ N/A
   ☐ NO
   ☐ YES ______ days prior to treatment

3. Is there any other reason for any medications to be added / discontinued or altered prior to non-invasive preventative dental care?

   ☐ NO
   ☐ YES

   Please list any add'l reasons below:

   ____

Thank you for your prompt response!

Please return this form to: cascadehygiene@gmail.com

Cascade Hygiene provides mobile dental care to people who are unable to travel to the dental office.
cascadehygiene.com | (360) 362-0151 | PO BOX 5842 Bremerton, WA 98312