Dental Clearance for Cardiac Procedure

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Physician's Name:

Physician's Phone:

Patient's Name:

Patient's DOB:

Date of Dental Exam:

Are There Acute Dental Infections Present? **Y** **N**

If "Yes", Recommended Treatment:

Extractions **Y** **N**

Periodontal: **Y** **N**

Estimated Time Until Clearance:

Patient has dental clearance for cardiac procedure:

_____ _____

David Mangot, DMD PC **Date**