DENTAL CLEARANCE FORM

PLEASE HAVE YOUR DENTIST COMPLETE ALL SECTIONS OF THIS FORM AND FAX IT TO 216.445.9608

If you have had your teeth removed/wear dentures, you do NOT need to get dental clearance before your surgery.

Surgeon's Name: _____ **Phone #**_____

Patient's Name: _____ **Cleveland Clinic #**_____

The patient is tentatively scheduled for open-heart surgery the week of: ____/____/_____

Please contact the patient's cardiologist for pre-op medication or anticoagulation recommendations.

Date of patient's last dental exam: ____/____/_____

IMPORTANT NOTE: In order for the patient to be cleared for surgery, he/she must have a dental exam that includes full-mouth X-rays and/or panorex within the 6 months prior to the above surgery date and must not have any signs of acute infection.

Does the patient have any acute dental infections? ☐ Yes ☐ No
If yes, please document and call the surgeon at the number listed above.

Dentist's Name: _____

Dentist's Signature: _____

Date: ____/____/_____ Time: _____

Phone # _____ Fax # _____

Thank you for your cooperation.

9500 Euclid Avenue, Cleveland, Ohio 44195
clevelandclinic.org/heart

Rev. 4/19
370845