Date: [Date]

To: [Dentist Name]
Dental Office: [Dental Clinic Name]
Fax/Email: [Contact Information]

RE: Medical Clearance for Dental Treatment

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

Dear Dr. [Dentist Last Name],

The above-named patient is currently under my care for the management of [List Medical Conditions, e.g., Hypertension, Diabetes, Cardiac Issues].

I have reviewed the proposed dental treatment, which includes [List Procedures, e.g., Extractions, Root Canal, Deep Cleaning]. Based on my recent evaluation, the patient is medically cleared to undergo these procedures with the following recommendations:

Pre-medication / Prophylaxis:
[ ] Not required.
[ ] Required (Antibiotic/Dosage): [Insert Details].

Anesthesia Precautions:
[ ] No restrictions.
[ ] Limit/Avoid Epinephrine due to [Reason].

Anticoagulation Management:
[ ] No changes to current medication required.
[ ] Hold [Medication Name] for [Number] days prior to procedure.
[ ] Latest INR (if applicable): [Value] on [Date].

Other Specific Instructions:
[Insert any additional notes regarding blood pressure limits, glucose levels, or stress protocols].

In my opinion, the patient is at [Low / Moderate / High] risk for the planned dental intervention. If you have any further questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name]
[Practice Address]