DENTAL CLEARANCE FORM

South Texas Bone & Joint Institute
Dr. Siraj Sayeed
210-696-2663 Office
210-696-2665 Fax

PLEASE FAX TO DR. SAYEED ONCE COMPLETED

*This form must be completed and available for review at the patient's pre-operative appointment with Dr. Sayeed.

PATIENT NAME: _____

DENTIST NAME: _____

DATE: _____

Please check ONE

☐ Patient **HAS NO** oral infections at time of dental visit.

☐ Patient **HAS** oral infection at time of dental visit.

Patient requires further dental treatment. (Please list)

_____

_____

SIGNATURE: _____