UNIVERSITY SQUARE DENTAL ASSOCIATES
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MEDICAL RELEASE

To: _____ Fax: _____

Dear Doctor:

_____ (patient's name) has given your name as his/her physician. We would appreciate your assistance in clarification of the patient's health. S/he has indicated that there is a prior history of (Dentist check appropriate condition):

___ Heart Murmur ___ Mitral Valve Prolapse

___ Prosthetic Heart Valve ___ Prosthetic Joint Replacement

___ Rheumatic Fever Other _____

Antibiotic Prophylaxis

Dental treatment, including filling, dental prophylaxis (cleaning), and injections may induce mild to moderate bleeding and bacteria due to gingival inflammation that may be present. Please inform if antibiotic prophylaxis is required for this patient:

□ Antibiotic prophylaxis **is** required for this patient

□ Antibiotic prophylaxis **is not** required for this patient

Use of Local Anesthetic

Please confirm if this patient may be treated with the use of local anesthetic that contains Epinephrine.

Check one of the following:

□ Xylocaine with Epinephrine may be used in the care of this patient.

□ No Epinephrine containing products may be sued in the care of this patient

Patient is cleared for the above procedure

□ Yes

□ No

Physician's Signature: _____ Date: _____

Please fax to (215)662-1015. Thank you for your assistance.

Medical Information Release

I hereby authorize any hospital or physician to release medical information regarding my health.

Patient's Signature: _____ Date: _____