WARREN ORAL SURGERY

COMPASSIONATE CARE

Surgical Medical Clearance Form

Medical clearance is needed from your physician **before your date of surgery**.

Your primary care physician should complete the attached form.

Please print a copy and take to your primary care physician's office for them to complete. We ask that you assist us in ensuring your primary care physician completes this form in a timely manner. If you are unable to take this form to their office, please direct them to our website at **www.warrenoralsurgery.com** and click on **Surgical Forms**.

Upon completion of this form, please fax to:

Attention: Patient Care Coordinator
Fax (908) 222-7923
Email: frontdesk@warrenoralsurgery.com

If you have any questions, please contact us via phone at (908) 222-7922

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Daniel P. Sullivan, DDS ▪ Prakhar Mehrotra, DDS ▪ Taneenop Aramphongphan, DMD

Pre-op Evaluation

This patient is scheduled for Oral Surgery in the near future. Please fax or email this form with any relevant supporting documentation to Warren Oral Surgery. Your assistance is greatly appreciated.

Patient's Name____ Birth date___ /___/___
Patient's Phone (HOME) _____________________ (MOBILE) ______________________
Pre-op Date____/____/____ Surgery Date____/____/____ Diagnosis ______________________________
Proposed Surgery ____
Anesthesia____
CC:

Significant past medical history: ____
____
____

List of previous operations: ____
____
____

Current medication with dosages:
____
____
____
____
____
____

Drug and Food Allergies:
____
____
____
____
____
____

B/P:___________ **Pulse:** ________

HEENT____

LUNGS____

CARD/VASC____

ABD____

EXT____

NEURO/PSYCH____

DIAGNOSIS____

Perioperative Recommendations:____

Is this patient cleared to have surgery? ____

Date: ____/____/____ **Print name:** __________________ **Signature**________________________

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