CARDIAC SURGERY DENTAL CLEARANCE FORM

Please have your dentist complete ALL SECTIONS of this form and FAX it to us.

Outpatient Department Fax # 216.445.9608 **Inpatient Department** Fax # 216.442.5875

If you have had your teeth removed/wear dentures, you do NOT need 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: ___/___/_____**

Clearance for surgery requires a dental exam that includes full-mouth X-rays and/or panorex within the 6 months prior to the above surgery date.

In addition, the patient must not have any signs of acute infection.

- **Does the patient have any signs of acute dental infection? ___ Yes ___ No**

If yes, please document and call the surgeon at the number listed above.

Dentist Name: ______________________________

Dentist Signature: ______________________________

Date: ___/___/_____ Time: ____________________

Phone # ____________________ Fax # ____________________

Thank you for your cooperation.

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

© 2000-2023 Cleveland Clinic. All rights reserved.

Rev. 5/23
1055072 / 370845