DENTAL CLEARANCE FORM

Interventional Cardiology Department: Structural Heart Disease Team
9500 Euclid Ave, Desk J2-3
Cleveland, OH 44195
Fax: 216.445.6179

Please complete this form and fax it to 216.445.6179 as soon as possible and bring a copy to your pre-procedure appointment.

Doctor's name: ____

Patient's name: ______________________ Patient's DOB: ________________

Patient's Clinic #: ____

This patient is scheduled for a structural heart procedure the week of: _____/_____/__________

A dental exam including full mouth x-rays and/or Panorex within the 6 months prior to the procedure is required. The patient must not have any signs of acute infection to be cleared for the procedure.

Date of patient's last dental exam: _____/_____/__________

Is the patient cleared for the procedure? ☐ **Yes** ☐ **No**

If no, please call 216.445.5557 and speak to the patient's doctor.

Dentist's name: ____

Dentist's signature: ____

Date: _____/_____/__________ Time: ______________________

Dentist's phone #:______________________ Dentist's fax #: ______________________

Thank you for your cooperation!

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