

Surgical Medical Clearance Form

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

Your physician should complete the attached form.

Please print a copy and take to your physician's office for them to complete. We ask that you assist us in ensuring your 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

WARREN ORAL SURGERY

— COMPASSIONATE CARE —

Daniel P. Sullivan, DDS ▪ Sanjeet Chaudhary, DMD ▪ Shawn Lynn, DDS

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 _____