Maine Medical
PARTNERS
Orthopedics & Sports Medicine

A department of Maine Medical Center

Dental Clearance Form

Please ask your dentist to complete this form and fax it to 207-781-1552.
If you have any questions or concerns, please contact your surgeon's office.

Patient name: _____

Patient date of birth: _____

Surgery date: _____

Surgeon: _____

I certify that:

- This patient has had a dental exam within the past 2 years
- This patient has had a dental cleaning within the past 6 months
- The patient does not have an active dental infection or abscess that requires treatment before surgery

Dentist name (please print): _____

Dentist signature: _____

Dental office: _____

Today's date: _____

Date of patient's last dental exam: _____