KAISER PERMANENTE®

Division of Cardiothoracic Surgery
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Dental Clearance For Surgery

Patient's Name: _____ Date of Birth: _____

Date of Operation: _____

Date of Dental Examination: _____

Date of last teeth cleaning: _____ **(Needs to have been done within the last 6 months)**

DATE OF TREATMENT COMPLETION: _____
(If treatment is needed, we request treatment to be completed 2 weeks before surgery)

Is the patient **FREE of any acute dental and/or gum infection** that would increase the risk of endocarditis prior to heart surgery? **YES** □ **NO** □

If NO, what is the treatment plan?

_____
_____
_____
_____
_____
_____

Please send a new dental clearance letter from your office once treatment is completed. Thank you.

Dental office stamp/card

_____
Dentist's Signature **Date**

Dentist's Printed Name:_____

Dental Office Phone #: _____
Dental Office Fax #: _____

Revised 4.3.2017