PARAMOUNT ORAL SURGERY

COMPASSIONATE CARE

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.paramountoralsurgery.com**. The form is located under the **Patient Info tab followed by Patient Forms**.

Upon completion of this form, please fax to the appropriate office listed below:

Attention: Patient Care Coordinator

❑ **201 Edward Curry Ave, Staten Island, NY 10314**	**718-494-2053**	**Fax 718-494-2053**
❑ **1 Broadway, Suite 101, Elmwood Park, NJ 07407**	**201-794-3344**	**Fax 201-794-0454**
❑ **925 Broadway, 1st Floor, Bayonne, NJ 07002**	**201-858-1400**	**Fax 201-858-0503**
❑ **50 Park Place, Suite 1540, Newark, NJ 07102**	**973-643-1130**	**Fax 973-643-1537**

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COMPASSIONATE CARE

Surgical Medical Clearance Required

Please provide your physician's information so we can obtain a medical clearance prior to your date of surgery.

Patient Name: _____ Date of Birth: _____

Physician Name: _____ Specialty: _____

Phone Number: _____ Fax Number: _____

City: _____ State: _____

Physician Name: _____ Specialty: _____

Phone Number: _____ Fax Number: _____

City: _____ State: _____

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For more information please visit us at www.paramountoralsurgery.com

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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 Paramount 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**_____

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