PARAMOUNT ORAL SURGERY
COMPASSIONATE CARE

Surgical Medical Clearance Form

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

Your primary care physician should complete the attached form.

Please print a copy and take to your primary care physician's office for them to complete. We ask that you assist us in ensuring your primary care 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** and click on **Surgical Forms**.

Upon completion of this form, please fax to:

Attention: Patient Care Coordinator
Fax (718)-285-8060
Email:frontdesk@paramountoms.com

If you have any questions, please contact us via phone at (718)-494-2053.

201 Edward Curry Avenue, Suite 101, Staten Island, New York 10314
Tel 718-494-2053, Fax 718-285-8060
Email: frontdesk@paramountoms.com
www.paramountoralsurgery.com

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Daniel P. Sullivan, DDS - Adam Schuessler, DMD, MD - Avichai Stern, DDS
Michael Awadallah, DDS, MD - Shawn Lynn, DDS

Pre-op Evaluation

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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