Dental Clearance for Bisphosponate Therapy

Date_____

To _____

Re _____

DOB _____

Dear Doctor,

Our mutual patient has been instructed that they will be recieving bisphoshonate therapy. We recommend that their teeth be evaluated for needing cleaning, necesaary filings, extractions of nonresorable teeth ,and elimination of infection so that they may recieve the best possible outcome from both a medical and dental stand point.

Patient is cleared for therapy

yes ☐ no ☐

If no what are the dental recomendations -

Dentist signature

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