

Thompson Ray Bogert, D.D.S.
Pediatric Dentist
1220 Clear Lake City Blvd.
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MEDICAL CLEARANCE

Date: _____

Dr. _____

Address: _____

City, State: _____

Phone: (_____) _____

Fax: (_____) _____

Patient's Name: _____

Date of Birth: _____

Medical Issue: _____

_____ Yes, antibiotic coverage needed for dental procedures.

_____ No, antibiotic coverage not needed for dental procedures.

Signature of Doctor Date

Signature of Parent Requesting Information Date

Thompson Ray Bogert, DDS
Specialist in Pediatric Dentistry
Fax back to: 281-480-4935

