Orthodontic Clearance Form

Patient Name: _____ **Date of Birth:** _____

The oral health of our patients is very important to us. For that reason, we require them to visit their general dentist for regular dental cleanings and evaluation (every 6 months) before, during and after orthodontic treatment is completed. The patient noted above is interested in starting orthodontic treatment at our office. In order to start treatment, we require clearance from their general dentist. Please evaluate this patient and complete the questionnaire below; indicating whether orthodontic treatment is appropriate currently. Thank you!

Date of Last Dental Cleaning: _____

Date of Last Dental Examination: _____

Was any decay or need for treatment noted? Yes _____ No _____

If yes, when do you expect treatment to be completed? Date _____

Are periodontal findings consistent with good oral health? Yes_____ No_____

Is this patient cleared to begin orthodontic treatment? Yes_____ No_____

Is an orthodontic treatment plan needed before deciding on a restorative plan? Yes_____ No_____

Additional Comments:

_____

_____

Dentist Name (Please Print) _____

Phone Number _____ **E-mail** _____

Dentist Signature _____ **Date** _____

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