GEORGIA SCHOOL OF ORTHODONTICS

DENTAL CARE CLEARANCE FOR ORTHODONTIC TREATMENT

Date: _____

Patient Name: _____ DOB: _____

Dental Care Provider: _____

Phone Number: _____ E-mail Address: _____

This patient has informed us that you are their dental care provider and they have had a preliminary evaluation to move forward with Orthodontic care at the Georgia School of Orthodontics.

We require that all of our patients are up to date with their general dental care before we can initiate orthodontic treatment.

Please provide us with the information below so that we can begin their treatment. If you have any questions, please let us know!

Date of Last Cleaning: _____

Date of Last Dental Exam: _____

Any Decay? Yes _____ No _____

If yes, has all decay been restored? Yes_____ No_____

If not, when do you expect treatment to be completed? Date: _____

Are perio findings consistent with good oral health? Yes_____ No_____

Is this patient cleared to begin Orthodontic treatment? Yes_____ No_____

Dentist Name *(Please Print)*: _____

Phone Number: _____ E-mail: _____

Dentist Signature: _____ Date: _____

Please fax this form to 770.538.1531 or e-mail it to clinic@gaorthodontics.org.