



DENTAL CARE CLEARANCE FOR ORTHODONTIC TREATMENT

Georgia School of Orthodontics partners with our patients' dentists as we require that every patient is up to date with their general dental care before we can initiate orthodontic treatment.

A mutual patient has completed a preliminary evaluation to move forward with orthodontic care at GSO. Please provide us with the information below so that we can begin their treatment. If you have any questions, please let us know!

Patient Name: _____ DOB: _____

Dental Care Provider: _____

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 that treatment will 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 have the patient bring this form to their next appointment at GSO.