Dental Reward Certificate

Patient Name_____ Date_____ Phone_____

is being referred to your office for

☐ **General Evaluation/Caries Clearance** ☐ **Treatment Pending** ☐ **Extraction(s)**
Please see attached

EVALUATION: Our Findings

_____

_____

_____

TO BE COMPLETED BY THE GENERAL DENTIST

Examination Date_____ Hygiene/Cleaning Date_____

1. Following Treatment Has Been Rendered: ☐ **No Caries Present** ☐ **Exam/Cleaning**

_____

_____

2. Treatment Not Yet Completed: _____

_____

_____

3. Recommendations:

☐ Caries present. Do not start/continue orthodontic treatment until notified by our office.

☐ Sealants - occlusal pits/fissures 1st and 2nd permanent molar teeth.

☐ Other_____

I certify that a dental examination and evaluation, including screening for periodontal disease, has been completed for this patient. The patient's dental and periodontal condition is clear and ready to start treatment.

_____ _____
General Dentist Name License No.

_____ _____
Signature Phone

FORM MUST BE SIGNED BY DENTIST & RETURNED TO ORTHODONTIST BY NEXT APPOINTMENT

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