Dental Clearance 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:

_____

_____

2. Treatment Not Yet Completed: _____

_____

3. Pending Treatment Scheduled For: _____
Date

4. Recommendations:

◯ Okay to continue or start orthodontic treatment.

◯ Do not continue or start orthodontic treatment.

◯ 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

beth's braces orthodontics

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