Date: ____/___/____

Dental Clearance to continue Orthodontic treatment

Dear Dr._____ ,
We are referring patient to your office for complete Dental Examination and treatment as necessary.

Patient: _____ DOB: ____/____/_____

In conjunction with above named patient's future orthodontic therapy, please provide a complete dental evaluation and treatment as needed.
Upon completion of the dental examination and treatment, please return this form to our office:
Email: dds@bronxadvanced.com, Fax: (917) 792-7979

Date of dental exam: _____ Date of dental cleaning: _____

Please check all that apply:

☐ Patient has received an oral examination and was found to be free of untreated oral disease or other conditions that may make orthodontic treatment unsuccessful or harmful.
☐ The patient demonstrates oral hygiene habits consistent with being able to prevent inflammation and dental decay during orthodontic treatment.
☐ Sealants are in place on all of the patient's unrestored erupted permanent molars if applicable.
☐ The patient has all needed dental treatment completed and is able to start(or continue) orthodontic treatment.
If unable to check off all statements listed above, please list any conditions that patient still needs treated:

_____
_____
_____

For Patient (guardian): Please return this letter before your next appointment.