ICONIC
ORTHODONTICS

Orthodontic Treatment Clearance Form

Patient Information

Name _____ **Date of Birth** _____

The oral health of our patients is very important to us. For that reason, we require them to visit their general dentist for regular dental cleanings and evaluation (every 6 months) before, during and after orthodontic treatment is completed. The patient noted above is interested in starting orthodontic treatment at our office. In order to start treatment, we require clearance from their general dentist. Please evaluate this patient and complete the questionnaire below; indicating whether orthodontic treatment is appropriate currently. Thank you!

Date of Last Dental Cleaning _____

Date of Last Dental Examination _____

Was any decay or need for treatment noted? **Yes** _____ **No** _____

If yes, when do you expect treatment to be completed? **Date** _____

Are periodontal findings consistent with good oral health? **Yes**_____ **No**_____

Is this patient cleared to begin orthodontic treatment? **Yes**_____ **No**_____

Comments

_____

_____

Dentist Name (Please Print) _____

Phone Number _____ **E-mail** _____

Dentist Signature _____ **Date** _____