THRIVE
DENTAL & ORTHODONTICS

ORTHODONTIC NEW PATIENT AND RECALL REFERRAL

Dear Doctor,

Please perform the treatment indicated below. When completed, please sign, date, and return to Thrive Dental and Orthodontics via the patient or email.

Patient:_____ Date:_____

This is a patient from the orthodontic department at Thrive Dental and Orthodontics, therefore please:

1. Do palliative treatment only on any bicuspid tooth, until orthodontic diagnosis is completed.
2. No bridges until after orthodontic treatment.

_____ Prophylaxis: Scaling and Polishing.
_____ Periodontal Evaluation and treatment-Full perio probing and charting.
_____ If the above perio care is not sufficient then please refer to a periodontist.
_____ Caries check: Complete all necessary restorations

Orthodontist Signature:_____ Date:_____

Office Location: :_____

TO BE COMPLETED BY GENERAL DENTIST:

1. I certify that the following treatment has been rendered:
   _____
   _____
   _____
   _____
2. Comments and/or additional treatment needed:
   _____
   _____
   _____
   _____
3. By signing my name, I am certifying that this patient's periodontal condition is clear and the patient is ready for orthodontic treatment.

Doctor Signature:_____ Date: _____

Doctor Name:_____ Practice name: _____