DENTAL CLEARANCE FORM

Patient: _____ DOB: _____ Date:_____

Dear Doctor,

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 (or SRP and perio maintenance if required)
____ 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

Doctor Signature:_____ Date:_____

Office Location: _____

TO BE COMPLETED BY RESTORATIVE DENTIST:

1. I certify that the following treatment has been rendered:
   _____
   _____
   _____

2. Comments and/or additional treatment needed:
   _____
   _____
   _____

3. By signing, I certify that this patient is cleared periodontally and is ready for orthodontic treatment.

Doctor Name: _____ Doctor Signature: _____

Practice Name: _____ Phone #: _____ Date: _____