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TIME SENSITIVE requirement!

THIS FORM MUST BE RETURNED TO OUR OFFICE BEFORE TREATMENT BEGINS.

PATIENT NAME: _____ **DOB:** _____ **Referral Date:** _____

Dear Patient: ***Please have this form filled out by your dentist or dental hygienist.***
We require this form to be completed before orthodontic treatment starts. Optimal dental health requires routine teeth cleanings and cavity checks before, during, and after orthodontic treatment. We recommend cleanings every 6 months, but understand some insurance policies only allow for this procedure every 6-12 months. Orthodontic care does not substitute your regular dental needs so please routinely check in with your regular dentist. The consequences of poor oral hygiene can lead to permanent, sometimes irreversible, tooth and gum damage.

Dear Doctor/Hygienist: – The patient named above will be starting orthodontic treatment soon. Their hygiene and dental care are VERY important to us and we ask that you clear them for treatment before we begin by filling out this form. We will encourage our mutual patient to maintain their routine cleanings and check-ups. If you have any concerns or comments regarding this patient's care, please do not hesitate to contact us.

Scheduled Start date (if applicable): _____

THIS CERTIFIES THAT OUR PATIENT HAS COMPLETED THE FOLLOWING:

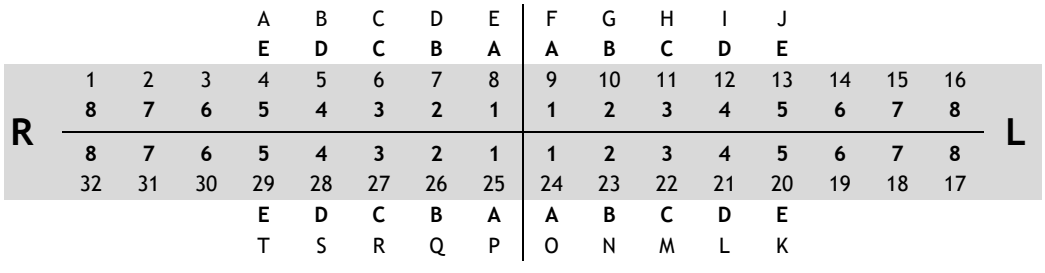
❑ Dental Exam **Appt Date:**_____ ❑ Dental Cleaning **Appt Date:** _____ ❑ No Cavities ❑ Treatment Pending

Dentist Name & Office Phone No.: _____

Dentist Signature: _____

Description of Pending Treatment, tooth numbers: _____

_____



*Please be advised that any dental treatment involving the following procedures may affect orthodontic treatment. We ask that before the procedures are performed, it be brought to our attention so that we may discuss and plan treatment accordingly. Such procedures include, but are not limited to:

- Fillings
- Bondings
- Partials
- Bridges
- Implants
- Extractions
- Crowns
- Veneers
- Root canals