

DENTAL CLEARANCE FORM

Patient:

Date of Birth:

Treating Dentist Name: _____
Dental Office: _____
Phone Number: _____

Purpose of This Form

The above-named patient is currently under consideration for orthodontic treatment. Prior to initiating or continuing orthodontic care, we require confirmation that the patient is in a stable state of oral health.

Dental Evaluation (To Be Completed by Treating Dentist)

Please evaluate the patient and indicate the current status:

Caries (Tooth Decay):
☐ No active caries
☐ Active caries present (please specify): _____

Periodontal / Gingival Health:
☐ Healthy / stable
☐ Gingivitis present
☐ Periodontal concerns (please specify): _____

Oral Hygiene:
☐ Good
☐ Fair
☐ Poor

Restorative Needs:
☐ No pending treatment
☐ Treatment needed (please specify): _____

Dental Hygiene Needs:
☐ Last Dental Cleaning _____
☐ Current hygiene interval _____
☐ Recommended hygiene interval with appliances _____

Radiographs:
☐ Up to date
☐ Not up to date

Clearance Status
Please select one:

☐ Cleared for orthodontic treatment
Patient is in good oral health and may proceed with orthodontic care.

☐ Not cleared for orthodontic treatment at this time
Orthodontic treatment should be delayed until the following issues are addressed:

Additional comments/ Recommendations:
_____
_____
_____
_____

I confirm that I have evaluated this patient and provided the above information to the best of my knowledge.

Dentist Signature: _____
Date: _____