



Dental Clearance Form

Patient Name: _____

Patient DOB: _____

Our mutual patient is ready to begin orthodontic treatment. Before I start treatment, I would like to confirm stable periodontal health to ensure the best possible outcome for our patient. Please evaluate and advise me of any precautions regarding their restorative and periodontal condition. Please complete the items below:

- Date of last exam: _____
- Date of last prophy and/or periodontal treatment: _____
- Periodontal health status: _____
- Restorative status: () Completed () In progress () Post orthodontic restorative plan
- Do you approve the patient to start orthodontic treatment? _____
- Additional comments: _____

Please email completed form to info@riverorthonh.com or fax to 603-424-5566. I appreciate you taking time to complete and return this form. If you have any questions, please feel free to contact my office. Thank you for your continued partnership in our patient's oral health.

Dentist Name (please print): _____

Dentist Signature: _____ Date: _____