DENTAL CLEARANCE NOTE

Date: _________________

Dear: Primary Dentist

Patient's Name:

In conjunction with the above named patient's future orthodontic therapy, please provide a complete dental evaluation and treatment as needed.

Upon completion of the dental examination and treatment, please mail this form to our address. For your convenience, it can also be received via fax: or email: . The form is needed for our records.

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Please be informed that the dental health of the above patient is satisfactory to receive orthodontic therapy.

Comments:____

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Dr:______________________

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