



BELTWAY ORTHODONTICS

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ORTHODONTIC CLEARANCE FORM

Patient Name

Date of Birth

would like to begin orthodontic treatment at our office.

Please review this patient's oral health status and sign below indicating that at the time of your most recent exam on ___/___/___ this patient :

- Did not have active periodontal disease, lacks mobile or periodontally compromised teeth, and is free other periodontal conditions requiring immediate attention.
- Was up to date with recommended prophylaxis or periodontal maintenance regime and has scheduled future recall appointment.
- Was free of carious lesions and defective/unstable restorations that will not allow orthodontic movement and/or band or bracket placement.
- Was free of oral pathologies

Based on your recent examination this patient (Please check one):

Fits the above criteria

Does not fit the above criteria

Areas of concern or needed treatment:

Please email, fax, or have patient return this form to our office. We know you are busy and sincerely appreciate your willingness to help serve your patient.

Office Name

Office Phone Number

Doctors Signature

Date