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AIRWAY FOCUSED ORTHODONTICS/ORAL APPLIANCE THERAPY CLEARANCE FORM

Please have your Dentist fill out this form and bring it to your Initial Consultation. Or have your Dentist **FAX** the completed form to **Dr. Barnhart's office at: (530) 222-1484.**

NAME OF PATIENT: _____ DOB: _____

I, Dr. _____, certify that the above mentioned patient meets the following criteria:

Recent Dental Cleaning?
[ ] Yes [ ] No Date: _____

All necessary dental restorations are complete?
[ ] Yes [ ] No

Patient's Perio condition clear?
[ ] Yes [ ] No

Patient is clear for airway focused orthodontics or oral appliance therapy?
[ ] Yes [ ] No

Comments from Dentist:

_____
_____
_____
_____
_____

_____ _____
Dentist's Signature **Date**