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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:________________

Type of Cleaning Patient is Receiving:
[ ]Prophy [ ]SRP's [ ]Perio Maintenance [ ]Other___________________

Recent FMX?
[ ] Yes [ ] No Date:________________

Recent BTW?
[ ] 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 appliance therapy?
[ ] Yes [ ] No

Comments from Dentist:

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Dentist's Signature **Date**