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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:_____

Please send a copy of recent x-rays to:
office@rachelbarnhartdds.com
(Dexis Format Preferred)

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

***PATIENT IS CLEARED FROM A DENTAL STANDPOINT? [ ] Yes [ ] No**

Comments from Dentist:

_____
_____
_____
_____
_____

_____ _____
Dentist's Signature **Date**