The Orthodontic Care Center

Dental Clearance Form for Orthodontic Treatment

This patient will be starting orthodontic treatment. Before the orthodontic treatment can be initiated, all general dental care including prophylaxis must be completed. Upon completion of all needed treatment please have your **DENTIST** complete this form, sign and give to the parent/guardian or fax to our office.

Thank you.

____

Patients Name   Date of Birth

I have completed all necessary dental treatment for this patient.

____

Dentist Signature

____

Dentist Name or stamp   Date

The Orthodontic Care Center
1421 S 108th Street, West Allis, WI 53214
2359 Murphy Woods Road, Beloit, WI 53511
Tel: 414-771-5100   Fax: 414-908-9384