BOLD BITE ORTHODONTICS
14035 Beach Blvd, Suite 104, Jacksonville, FL 32250 | 904-595-6869 | orthodontistjacksonville.com

Dental Clearance for Orthodontic Treatment

To be completed by the patient's general dentist or hygienist

Dear Colleague: This patient is preparing to begin orthodontic treatment at Bold Bite Orthodontics. Before braces or aligners are placed, we ask that the dentition be healthy and stable: no active decay, controlled periodontal status, and a recent professional cleaning. Please complete this form, sign the clearance decision, and return it to our office. We appreciate your partnership in your patient's care.

Return completed form to: appointments@myboldbite.com or have the patient bring it to their consultation.

SECTION 1 PATIENT INFORMATION

Patient name: _____ **Date of birth:** _____

Date of most recent dental exam: _____ *(clearance valid 6 months from this date)*

SECTION 2 REFERRING DENTAL OFFICE

Practice name: _____ **Phone:** _____

Dentist / hygienist name: _____ **Email:** _____

SECTION 3 CLINICAL STATUS

Date of most recent professional cleaning (prophy / SRP):

Most recent radiographs taken:

☐ Bitewings ☐ Periapical ☐ Panoramic ☐ Full mouth series

Date taken: _____ ☐ Available to share on request

Caries (decay) status:

☐ No active caries ☐ Active caries present (described below)

If present, is treatment scheduled or planned? ☐ Yes ☐ No

Periodontal status:

☐ Healthy ☐ Gingivitis ☐ Periodontitis (localized)

☐ Periodontitis (generalized) ☐ Currently under active periodontal therapy

Calculus / plaque deposits:

☐ None to minimal ☐ Moderate to heavy (cleaning recommended before ortho)

Overall oral hygiene:

☐ Good ☐ Fair ☐ Poor

SECTION 4 CURRENT OR PENDING DENTAL TREATMENT PLAN

Is there outstanding dental treatment to be completed before orthodontics? ☐ No ☐ Yes (list below)

SECTION 5 NOTABLE FINDINGS FOR THE ORTHODONTIST

Missing teeth, planned extractions, impacted teeth, existing crowns / bridges / implants, TMD or jaw concerns, parafunctional habits, or anything else we should know:

SECTION 6 CLEARANCE DECISION

☐ **Cleared to begin orthodontic treatment.**
☐ **Cleared with conditions.** Specify:

☐ **Not cleared at this time.** Recommended before clearance:

This clearance is valid for six (6) months from the date of exam recorded in Section 1.

Dentist / hygienist signature | License # | Date

Printed name

SECTION 7 PATIENT AUTHORIZATION TO SHARE INFORMATION

I authorize my dental office to release the information on this form to Bold Bite Orthodontics, and I authorize Bold Bite Orthodontics to request and receive it, for the purpose of coordinating my orthodontic care.

Patient (or parent / guardian) signature | Date

Thank you for completing this form and for helping ensure our mutual patient is well taken care of. We look forward to working together to serve them.

Dr. Marty Greenberg & Dr. Trang Cao
Husband-and-wife team at Bold Bite Orthodontics