DENTAL CLEARANCE FORM

To be filled out by the applicant's dentist. This form is to be completed prior to submitting application.

Patient's Full Name: _____

Dentist's Name: _____

Dentist Address: _____

City, State: _____ Zip Code: _____

Dentist Office Phone Number: _____ Email Address: _____

GENERAL INFORMATION

Does the patient need restorative work at this time? Yes ( ) No ( ) Date of last cleaning: _____

Does the patient have good oral hygiene? Yes ( ) No ( ) Does the patient have baby teeth? Yes ( ) No ( ) If so, how many? _____

Impacted Teeth?: Yes ( ) No ( ) If so, how many: ____ Missing Teeth?: Yes ( ) No ( ) Have second molars erupted?: Yes ( ) No ( )

Other Functional or Esthetic Issues/Additional Comments:

_____

_____

How long have you been treating the patient? _____ Does the patient have a positive and respectful attitude?: _____

Does the patient keep appointments?: Always Mostly Sometimes Rarely Never

ADDITIONAL INFORMATION

Dentist Signature: _____ Date: _____