Vitral ORTHODONTICS

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# CONFIRMATION OF DENTAL EXAMINATION AND PERIODONTAL SERVICES

Patient printed name: _____ Date of Birth: _____

*THIS FORM CONFIRMS THE FOLLOWING PROCEDURES WERE COMPLETED ON* _____.
Date

- ☐ Comprehensive Dental Examination
- ☐ Complete Visual Periodontal Exam
- ☐ Prophylaxis
- ☐ Fluoride Application
- ☐ Necessary Dental Restorations
- ☐ X-rays for Bone Height Evaluation
- ☐ Full periodontal probing and charting

**Is this patient currently able to start orthodontic treatment?** ☐ **YES** ☐ **NO**

Notes:

_____

_____

_____

Upon examination and records, nothing has been found that would prevent this patient from having orthodontics treatment at this time.

Once orthodontic treatment is started, we will remind Alain to maintain 6-month recalls with your office. We appreciate your help filling out this form.

_____ _____ _____
DENTAL OFFICE DENTIST SIGNATURE DATE

**This form is required to be filled out and sent back to our office directly from the dental office via fax or email:**

**Fax**: 407.907.6362
**Email**: hello@vitralorthodontics.com

Thank you from the Vitral Orthodontics Team!