DENTAL CLEARANCE FORM

Dear Dental Care Provider,

Your patient is applying for an orthodontic assistance through the Embracing Our Warriors program. This program assists disabled veterans and their immediate family with orthodontic treatment. As a dental care provider, it is very important we receive feedback from you in regards to your patient so we can determine whether or not they will be a good candidate for our program.

To be filled out by the applicant's dentist.

Patient Name: _____
Last First

Dentist's Name: _____

Dentist's Address _____

Dentist's Phone Number: _____ Email Address: _____

GENERAL INFORMATION

Does the patient need restorative work at this time? (Please circle) **Yes No**

Does the patient have good oral hygiene? **Yes No** Date of last cleaning: _____

Is there any dental work needed before the patient begins orthodontic treatment? Is so,please explain:

_____

Functional or Aesthetic 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: (please circle one) Always Mostly Sometimes Rarely Never

ADDTIONAL INFORMATION :

_____

_____

_____

_____

Please return by email to info@EmbracingOurWarriors.org