Valleywide Dental Inc.
Orthodontics
1021 West Avenue M-14
Palmdale, CA 93551
(661)267-4000

Cavity Clearance

Patient Name:__________________________________ **DOB:**____________________ **Referral Date:** ________________

Dear Patient: We require this form to be completed during the course of orthodontic treatment. Optimal dental health requires routine teeth cleanings and cavity checks before, during, and after orthodontic treatment. We recommend cleanings every 6 months and orthodontic care does not substitute your regular dental needs, so please routinely check in with your regular dentist. The consequences of poor oral hygiene can lead to permanent, sometimes irreversible, tooth and gum damage. ****Please have this form filled out by your dentist or dental hygienist.***

Dear Doctor/Hygienist: The patient named above is in orthodontic treatment. Their hygiene and dental care is VERY important to us. We will encourage our mutual patient to maintain their routine cleanings and check-ups. If you have any concerns or comments regarding this patient's care, please do not hesitate to contact us. Scheduled next visit (if applicable):_________________

This certifies that our patient completed the following:

☐ **Dental Exam** ☐ **Dental Cleaning** ☐ **No Cavities** ☐ **Cavities, how many?** ________

Appt. Date:____________________ **Appt. Time:** ____________________

Dentist Name: ____

Dentist Signature:____

Comments (if any): ____

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*Please be advised that any dental treatment involving the following procedures may affect orthodontic treatment. We ask that before the procedures are performed, it be brought to our attention so that we may discuss and plan treatment accordingly. Such procedures include, but are not limited to:

- Fillings
- Extractions
- Bonding's
- Partials
- Veneers
- Bridges
- Root canals
- Crowns