



GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist and/or hygienist

Date: _____ \ _____ \ _____

Applicant's Name: _____

Applicant's Birthdate: _____ \ _____ \ _____

General Dentist: _____

Office Phone: (_____) _____ - _____

of remaining primary teeth: _____

Dental conditions that could be improved with orthodontic treatment: _____

Date of last dental cleaning & exam: _____ \ _____ \ _____

Please check one:

_____ Patient has received a cleaning and is cavity free.

_____ Patient has received a cleaning and completed all restorative treatment.
No additional treatments are necessary.

_____ Patient has received a cleaning & restorative treatment has been scheduled.
List restorative treatment needed & scheduled dates treatment is to be completed:

Signature of Dentist/Hygienist

Printed name of Dentist/Hygienist