



SHAH ORTHODONTICS

Let Our Family Em*Brace* Yours

Jalpan Shah DDS MDS
Orthodontics for Children & Adults

15385 Main St., Suite # 102
Hesperia CA 92345

Phone: (760) 244-2005
Fax: (760) 244-8955
braces@shahorthodontics.com

Date: _____

Patient Name: _____ DOB: _____

To: Dentist

Re: Cavity Clearance for Orthodontic Treatment

Dear Doctor,

Please evaluate and provide the necessary treatment indicated below. When completed, please sign, date and return it, via the patient and/or fax it directly to our office.

Our Office Fax No. is: **(760) 244-8955**

- ✓ Prophylaxis, Fluoride and Scaling.
 - ✓ Caries Check: Complete All Necessary Restorations And/or Sealants
 - ✓ Periodontal Evaluation and Treatment - Full Perio Probing & Charting.
- Please do only palliative treatment on any bicuspid tooth - Until Orthodontic diagnosis is completed.
 - Please No Crowns or Bridges - until after Orthodontics.
 - Please keep patient on regular 6 months recall.

If the above Periodontal Care is not sufficient, please refer patient to Periodontist.

Dr. Jalpan Shah DDS MDS

() I certify that the above dental work has been completed; patient's Perio condition is clear and the patient is ready to start/continue the orthodontic treatment.

Date of Exam/Cleaning: _____ Next recall due in 6 months or ____ months.

() Above dental work has not been completed and patient is not ready for orthodontic treatment. The following dental treatment needs to be completed before the start of orthodontic treatment:

() Please remove Upper arch wire Lower arch wire Brackets/Bands on teeth # _____ for dental work scheduled on _____.

Dentist's Signature

Date

Dentist Name: _____

Address: _____

Phone: _____ Fax: _____