DENTAL CLEARANCE FORM

Dear Dental Care Provider,

Your patient is applying for an orthodontic scholarship. ***If selected***, the patient will receive free braces through the Smile for a Lifetime Foundation. As the child's 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. If the form is incomplete, the application cannot be included in the selection process.

To be filled out by the applicant's dentist. This form is to be completed prior to submitting application.

Patient Name:	Last	First	Middle
Dentist's Name:	Last	First	Middle
Dentist's Address:	Street	City	State / Zip Code
Dentist's Contact info:	Office Phone Number	Alternate Number	Email address

General Information:

Does the patient need restorative work at this time? (Please circle one) Yes No							Date of last cleaning:				
Does the patient have good oral hygiene?	Yes	No	Does the patient have baby teeth:	Yes	No	If so, how many?					
Impacted Teeth:	Yes	No	If so, how many:		Missing Teeth:	Yes	No	Have second molars erupted:	Yes	No	

Other 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

Functional:

Malocculusion:	Class I	Class II		Class III
Crowding:	Mild	Moderate		Severe
Spacing:	Mild	Moderate		Severe
Overjet	Normal	Moderate		Severe
Underjet	Normal	Moderate		Severe
Overbite	Normal	Moderate		Severe
Underbite:	Normal	Moderate		Severe
Crossbite	None	Anterior		Posterior
Misalignment:	None	Mild	Moderate	Severe