Phone: (505) 600-2000 FAX: (505)600-2183

Dental Health Clearance for Ortho Placement

Patient Name: _____

DOB: _____/_____/_____

Dentist Name: _____

Last Prophy DOS: _____/_____/_____

I, _____ have completed a Comp Exam and verify that the patient listed above is cavity free and in good oral health ready for Orthodontics to be placed.

X _____

*If x-rays or records are to be transferred to us please send FMX, Pano, and Perio charting if taken.

Please send x-rays and records to:

Eubank: info.eubank@valerdental.com

Coors: info@valerdental.com

Info.eubank@valerdental.com

Thank you.