# SHAH ORTHODONTICS

*Let Our Family EmBrace Yours*

## Jalpan Shah DDS MDS

**Orthodontics for Children & Adults**

**14101 Main St., Suite # 104**
**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**

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( ) 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: _____