STATE OF NEW YORK
DEPARTMENT OF HEALTH

PATIENT RESPONSIBILITIES

Orthodontic care will improve your appearance, and ability to eat and speak. Because this treatment takes about three years to complete, it is important that you cooperate with your orthodontist.

Please make sure you follow these guidelines:

1. Keep all appointments.
2. Call the orthodontist at least one day in advance if you must cancel an appointment. Make sure another appointment is made.
3. Make sure you have all cavities filled before the orthodontic appliances are placed.
4. Make sure you wear the appliances as directed by the orthodontist.
5. Report immediately to the orthodontist any problems with the appliance or loss of an appliance.

Please call the Montefiore Department of Dentistry office if there is:

- a change of address or telephone number
- any problems you have with the orthodontic treatment

Thank you for your cooperation.

Montefiore Medical Center
Department of Dentistry- Orthodontics

STATE OF NEW YORK
DEPARTMENT OF HEALTH

-DENTAL CLEARANCE FORM-(Adults)

Dear Patient:

Now that you are ready for orthodontic treatment, it is necessary that you have a general dentist examine and treat you for tooth decay and other dental problems. After treatment is finished, please have your dentist complete the bottom half of this form. Bring the completed form that has been signed by your dentist to your orthodontist at the time of your first appointment.

Thank you.

DENTIST'S REPORT

Before orthodontic treatment can be initiated, all general dental care including prophylaxis must be completed. Upon termination of all needed treatment please complete the form, sign and give to the parent/guardian.

Thank you.

Patient's Name | Date of Birth

Home Address | Apt # | Borough/Zip Code

I have completed all necessary dental treatment for this patient.

Signature of Dentist | Address

Date | Telephone Number

ADULT

STATE OF NEW YORK
DEPARTMENT OF HEALTH

-DENTAL CLEARANCE FORM-(Adults) (Periodontist)

Dear Patient:

Now that you are ready for orthodontic treatment, it is necessary that you have a general dentist examine and treat you for tooth decay and other dental problems. After treatment is finished, please have your dentist complete the bottom half of this form. Bring the completed form that has been signed by your dentist to your orthodontist at the time of your first appointment.

Thank you.

DENTIST'S REPORT

Before orthodontic treatment can be initiated, all general dental care including prophylaxis must be completed. Upon termination of all needed treatment please complete the form, sign and give to the parent/guardian.

Thank you.

Patient's Name | Date of Birth

Home Address | Apt # | Borough/Zip Code

I have completed all necessary dental treatment for this patient.

Signature of Dentist | Address

Date | Telephone Number

ADULT

STATE OF NEW YORK
DEPARTMENT OF HEALTH

-MEDICAL CLEARANCE FORM-

Date: _____ Dental Clinic: _____

Dear Patient:

The medical history you have given us concerning you, _____ requires that you have this medical approval form filled out by your physician before we can treat you. After the physician completes the form, return it to your orthodontist. Orthodontic treatment will commence after this form is received.

El historial medico que usted nos ha provisto de paciente, _____ require que usted obtenga la aprobacion de su medico antes de comenzar el tratamiento. Por favor haga que su medico llene este modelo y devuelvlo a la direccion que aparece en el encabezamiento de esta carta. Si no recibleramos la informacion requerida el tratmeiento no podra ser iniciado.

The patient, _____

has the following medical history: _____

_____

_____

_____

_____

Please inform us whether any restrictions or special precautions are necessary in providing this child with dental care, including fillings, extractions, and the administration of local anesthetics, or orthodontics. Orthodontic appliances often cause chronic irritation of gingival tissues with some bleeding and occasional infection of gingiva. Please indicate if this patient requires prophylactic antibiotic; other special car; or if any special precautions are required during the lengthy treatment involved in orthodontics.

_____

_____

_____

Signature of Physician _____ Date _____

Address _____ Telephone number _____

ADULT