Dental Clearance Letter

Re: _____
DOB:_____

To Whom It May Concern,
Our mutual patient noted above is scheduled to begin oral appliance therapy for obstructive sleep apnea.

Prior to active oral appliance therapy, it is important to verify that the patient has had a dental exam within the past six months, has no current dental infection and no anticipation of extensive restorative dental or orthodontic care within the next six months excluding filings.

This letter is an important part of our pretreatment patient evaluation; please return the completed form to us as soon as possible.

Worcester Sleep Dentistry

Dr. Silvia Lobo Lobo

I certify that the patient (above)

- Has had a dental exam within the past six months
- Has no anticipation of extensive restorative dental or orthodontic care within the next six months
- Does not have a dental infection requiring treatment.

Date of last dental exam:

_____

Dentist name (please print):

_____

Dentist signature:

_____

Date:

_____
_____

If unable to verify these criteria, please describe any concerns you may have about this patient proceeding with oral appliance therapy for the treatment of obstructive sleep apnea:

_____
_____
_____
_____

Please fax this letter to

Worcester Sleep Dentistry