ATHENS
T: (706) 353-1700
F: (706) 353-1774

AUGUSTA
T: (706) 621-7586
F: (706) 621-7587

CARROLLTON
T: (678) 796-0511
F: (678) 796-0512

CASCADE ROAD
T: (404) 691-4848
F: (404) 691-5631

COLUMBUS
T: (706) 324-4665
F: (706) 653-6379

DOUGLASVILLE
T: (678) 619-1699
F: (678) 619-1701

GAINESVILLE
T: (678) 769-4909
F: (678) 769-4910

HIRAM
T: (770) 222-4450
F: (770) 222-4420

LAGRANGE
T: (706) 882-8081
F: (706) 882-8661

MACON
T: (478) 471-9300
F: (478) 471-9796

MADISON
T: (706) 342-7272
F: (706) 342-7747

McDONOUGH
T: (678) 432-8505
F: (678) 432-9419

ROME
T: (706) 591-8102
F: (706) 591-8103

ORTHODONTIC CARE OF GEORGIA

Orthodontic Treatment Approval

_____DOB:_____ is scheduled to visit our
Pt Name *Date of Birth*

office for an Orthodontic Consultation. Please let us know if you have any concerns or observations that would delay orthodontic treatment by completing the form below and return to our office via fax. We know that you are busy and sincerely appreciate your willingness to help us serve your patient. If you have additional concerns you may always call our office.

Thank you!

Patients last cleaning and exam:_____

Any known concerns:_____

All know dental procedures have been completed.

Name of Practice: _____

Dentist Name: _____

Phone Number: _____

Dentists Signature:_____Date:_____