

**Diagnostic and Treatment Form**

(Please read carefully and fill up the form completely)

**1-General Information**

Doctor's Name: \_\_\_\_\_ E-mail of Dr. \_\_\_\_\_

Shipping Address: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

**2-Primary concern of the patient**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3-Patient Diagnostic Information**

Dentition Mixed  Permanent

Treatment Indicated Both  Upper  Lower

Limited 

8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8
8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8

Treatment Deferred 

8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8
8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8

Midline Centered Upper  Lower

Shifted Upper R  L  Lower R  L

Permanent Canine Relationship Class I R  L  Class II R  L  Class III R  L

Permanent Molar Relationship Class I R  L  Class II R  L  Class III R  L

Incisor Relationship Overjet \_\_\_\_\_ mm Overbite \_\_\_\_\_ mm

Tooth Size Discrepancy Lower Jaw Excess  Deficient

Upper Jaw Excess  Deficient

Cross bite 

8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8
8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8

Cephalometric Values (Optional)

<u>Skeletal Analysis</u>	<u>Dental Analysis</u>
<SNA _____	<UI-SN _____
<SNB _____	<UI-Palat _____
<ANB _____	IMPA _____
WITTS value _____ mm	<u>Soft tissue Analysis</u>
<SN-Pg _____	<Nasolabial _____
<SN-Mand _____	U-Lip to E-Line _____ mm
<MMA _____	L-Lip to Eline _____ mm
<Y-Axis _____	

**4-Treatment Planning**

Product Type CP-A  CP-B  CP-S

Gain Space Proclination  Expansion  IPR

(Please specify your preference by writing 1,2, & 3 in the boxes below)

Proclination  Expansion  IPR

Space Closure Upper arch Complete  Leave space

Lower arch Complete  Leave space

(Complete space closure may require IPR. Default space will be left distal to laterals)

Arch Width Upper arch Maintain  Expand  Constrict

Lower arch Maintain  Expand  Constrict

Midline Maintain

Correct  Move Upper \_\_\_\_\_ mm Move Lower \_\_\_\_\_ mm

Permanent Canine Occlusion Goal Class I R  L  Class II R  L  Class III R  L

Permanent Molar Occlusion Goal Class I R  L  Class II R  L  Class III R  L

Required Overjet \_\_\_\_\_ mm Required Overbite \_\_\_\_\_ mm

Tooth Size Discrepancy IPR  Leave space

(Default space will be left distal to laterals, specify through comments if otherwise)

Correct Cross bite 

8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8
8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8

Recommended Extraction 

8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8
8,7,6,5,4,3,2,1	1,2,3,4,5,6,7,8

Nature of Patient: Overseas  Local

(Asked to avoid IPR scheduling, if required during non-availability of patient)

**5-Special Instructions**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_