

DR. _____

STREET _____ SUITE _____

CITY _____ STATE _____ ZIP _____

PHONE () _____ EMAIL _____




PATIENT NAME _____ AGE: _____ SEX: M F

CHECK TO USE OPTIMAL VALUES*




* If checked, do not fill the Customize Section.

CUSTOMIZE SECTION





UPPER PLATE Check one

<input type="checkbox"/> STANDARD  RECOMMENDED	<input type="checkbox"/> FULL 	<input type="checkbox"/> ANTERIOR 
WIDTH <input type="checkbox"/> Central only <input type="checkbox"/> Lateral to lateral <input type="checkbox"/> Canine to canine		





LOWER PLATE Check one

<input type="checkbox"/> STANDARD  RECOMMENDED	<input type="checkbox"/> FULL 	<input type="checkbox"/> ANTERIOR 
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UPPER BAND Check one

<input type="checkbox"/> SIMPLE BUCCAL  RECOMMENDED	<input type="checkbox"/> 3/4 	<input type="checkbox"/> SIMPLE LINGUAL 	<input type="checkbox"/> FULL 
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LOWER BAND Check one

<input type="checkbox"/> 3/4  RECOMMENDED	<input type="checkbox"/> SIMPLE LINGUAL 	<input type="checkbox"/> SIMPLE BUCCAL 	<input type="checkbox"/> FULL 
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PROTRUSIVE BITE

- Bite represents maximum protrusion (100%)
- Bite represents starting point

VERTICAL DIMENSION

- Close as much as possible
- Keep it, call if changes needed

LATERAL DEVIATION

- None
- Yes

BRUXISM

- None
- Light-moderate
- Severe



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SIGNATURE OF DENTIST _____

DENTIST LICENSE # _____

DATE ____/____/____