

IMPORTANT NOTE: In order to give you the most comprehensive analysis possible, please fill out the following form completely.

Doctor's Name: _____ Office Phone #: _____

Date: _____ Email (if requesting a Digital Report – see below): _____

Patient's Name: _____ Age: _____ Date of Birth: _____ Sex: _____

► TREATMENT OBJECTIVES:

Records alone are not sufficient for us to create an accurate treatment plan. Without having a clear understanding of your treatment goals, we could easily create a treatment plan that would not meet your needs. For example, evaluation of a patient's records may indicate the need to correct a skeletal Class II, when indeed, it is possible that your goals were only to correct anterior crowding and improve the esthetics. Clearly, in this example, the doctor's goals will dictate the treatment plan.

Describe, in detail, your major objectives of treatment (VERY IMPORTANT): _____

Describe your patient's major concerns (VERY IMPORTANT): _____

► TREATMENT PHILOSOPHY PREFERRED:

Please indicate any specific Clinician's treatment philosophy that you wish us to incorporate into this report: _____

► TYPE OF APPLIANCE PREFERRED:

Please check one of the following boxes: Removable Fixed No preference

► SEND COMPLETED REPORT IN THE FOLLOWING FORMAT:

Please check one of the following boxes: Digital Report Printed Report

NOTE: Printed Reports are the standard format unless otherwise requested. **Digital Reports** are returned as a PDF file.

► SHIPPING OPTIONS – How would you like us to return your order? Priority Mail UPS Blue UPS Red – Next Day

Signature: _____ License #: _____

APPLIANCE DESIGN SERVICE

This service is to assist you with **single-phase treatment based upon model evaluation only** (i.e. minor tooth guidance, habits, anterior crowding, early correction of crossbites, space maintenance, forced eruption, bruxism, etc).

NOTE: If additional records are being sent for evaluation (i.e. cephalometric film) or if a case needs multiple phases requiring orthodontic and orthopedic therapies, please refer to our *Orthodontic Diagnostic Service – see below*.

What we need – please refer to the “RECORDS” portion of this form for additional information

- Completed Doctor's Profile and Patient Profile Form
- Upper and Lower Working Models

What you receive:

- Written Summary of Treatment Objectives
- Treatment Recommendations
- A step-by-step Treatment Plan
- Appliance Adjustment Techniques
- Illustrated Appliance Design Description
- Completed Lab Prescription Form(s)
- Patient Instructions and References
- A set of Study Models (see below) – fees apply

ORTHODONTIC DIAGNOSTIC SERVICE

Knowing what cases to treat is as important as knowing how. The Orthodontic Diagnostic Service will allow you to make the clinical decisions to do both. This comprehensive service utilizes the patient's complete records to determine the best method of treatment while providing the clinician with the vital diagnostic information that is required to accomplish the stated treatment objectives. All of this vital information comes to you in a custom-bound report ready for your patient consultation.

What we need – please refer to the “RECORDS” portion of this form for additional information

- Completed Doctor's Profile and Patient Profile Form
- Upper and Lower Working Models
- Cephalometric Film
- Photographs – Full Patient Series
- Panorex
- NOTE: All of your materials will be returned.

What you receive:

- Written Summary of Records
- Comprehensive Model Analysis
- Patient Photographic Layout
- An in-depth Cephalometric Analysis
- Optional Ceph/Tracing/Photographic Superimposition(s)
- A Step-by-Step Treatment Plan
- Illustrated Appliance Design(s)
- Detailed Appliance Adjustment and Sequencing Techniques
- Completed Lab Prescription Form(s)
- Patient Instructions and References
- A set of Study Models (see below) – fees apply
- \$25.00 Voucher towards the fabrication of an appliance

CEPHALOMETRIC ANALYSIS PREFERRED (i.e. Sassouni Plus, IAO/Rondeau, Steiner, USDI, Mahony, McNamara, etc.) _____

NEW VISUAL AID OPTIONS

- Please include the Ceph Tracing superimposed over the Profile Photograph – fig. 1
- Please include the Ceph Tracing superimposed over the Cephalometric X-Ray – fig. 2
- Please include a V.T.O. – Visual Treatment Objective – fig. 3

The V.T.O. provides the “pre-treatment” (current) and the “treatment objective” (predicted) lateral view when the patient is placed to their “ideal” position. The V.T.O. images provided by the Second Opinion Diagnostic Service are for predictive purposes only. Actual treatment results may vary.

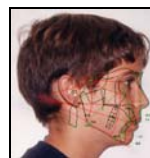


fig. 1



fig. 2



fig. 3

STUDY MODEL FABRICATION – OPTIONAL

CONSULTATION STUDY MODELS – FEES APPLY

Our Consultation Study Models are “direct copies” of the models that we receive. Any defects in the models received (i.e. air holes, stone bubbles, or chipped teeth are left “as is”). If this does not meet your particular needs please refer to our *Board Quality Orthodontic Study Models*.

BOARD QUALITY ORTHODONTIC STUDY MODELS – FEES APPLY

Our Board Quality Orthodontic Study Models meet all American Board of Orthodontic specifications. These models are trimmed to specific angles, hand sculpted and meticulously detailed with your patient's information printed on the back of the models.

Depending on the type of evaluation that has been requested, please include the following records as outlined below

GONE DIGITAL? – Digital patient records (cephalometric films, photographs, panorex, etc) can be submitted at www.ApplianceTherapy.com/SO or sent on a CD. We prefer digital image files to be in a JPG or JPEG format.

APPLIANCE DESIGN SERVICE

ACCURATE DIAGNOSTIC CASTS – REQUIRED

Necessary for accurate measurement of arch width, arch length, arch symmetry, and evaluation of occlusal relationships.

ACCURATE BITE REGISTRATION – REQUIRED

Absolutely essential regardless of the occlusal relationship.

PANOREX – Optional but helpful for a more in-depth diagnosis of the patient

To evaluate position of unerupted teeth, i.e. second and third molar position, and impacted cuspid position. Can also be used to determine growth direction in developing children – see “How to do Simple Orthodontics in the General Practice”, by Dr. Pfitzinger

PHOTOS (extraoral and intraoral) – Optional but helpful for a more in-depth diagnosis of the patient

Extraoral:
Profile – in maximum intercuspation with lips together
Profile – with mandible in relaxed posture
Frontal – with full smile
Frontal – with mandible in relaxed posture

Intraoral:
Upper Arch – occlusal view
Lower Arch – occlusal view
Frontal (Right, Center, Left) – teeth in maximum intercuspation, taken with cheek retractors in place

ORTHODONTIC DIAGNOSTIC SERVICE

ACCURATE DIAGNOSTIC CASTS – REQUIRED (see above for detailed description)

ACCURATE BITE REGISTRATION – REQUIRED (see above for detailed description)

PANOREX – REQUIRED (see above for detailed description)

PHOTOS – REQUIRED (see above for detailed description)

LATERAL CEPH – REQUIRED

Since malocclusions can be skeletal and dental in nature, it is necessary to determine the skeletal pattern (i.e. class I, II, III) and growth direction of a patient's development. A cephalometric evaluation is a critical tool when treatment planning any case that is beyond simple minor tooth movement.

FMX – Optional but helpful for a more in-depth diagnosis of the patient

To determine root development, presence of succedaneous teeth, periodontal health, space evaluation, timing of primary tooth exfoliation.

TOMOGRAMS – Optional but helpful for a more in-depth diagnosis of the patient

To evaluate condylar position and overall TMJ health. This is essential prior to treatment of any skeletal abnormalities and for anyone who exhibits TMD symptoms.

FINGER (wrist) X-RAY – Optional but helpful for a more in-depth diagnosis of the patient

Important to determine stage of development, i.e. has the patient passed their pubertal growth spurt. Essential in successful Functional Appliance Therapy.

Medical and Dental History

9129 Lurline Ave. Chatsworth, CA 91311 • P.O. Box 4184 Van Nuys, CA 91409-4184 • Phone 800.423.3270 Fax 818.341.4684 • www.ApplianceTherapy.com

In order to establish your treatment objectives, it is necessary to complete a thorough medical and dental history

▶ Describe any previous orthodontic treatment: _____

▶ Describe Oral Hygiene Habits: (patients with inadequate oral hygiene are poor candidates for fixed therapy)

▶ Are there any prosthetic considerations?(missing teeth, veneers, bridges, crowns, partials, etc)

▶ Are there any periodontal considerations?(Loss of crown length, tipped molars, food traps, etc. - any active periodontal disease must be addressed prior to beginning orthodontic therapy)

▶ Accidents: (can cause TMJ dysfunction, pupal damage, loss of the PDL and ankylosis) Describe:

▶ Does patient engage in any sports activities? (i.e. contact sports, basketball, biking, skating, etc.) Describe:

▶ Does patient play musical instrument? (i.e. trumpet, violin, clarinet, etc.) Describe:

▶ Airway Problems (Problems such as snoring, sleep apnea, allergies, enlarged tonsils and adenoids, or sinus obstruction can affect normal growth and development. Please check your patient carefully for any of these problems.) Describe:

▶ Tongue (Check your patient for tongue size, rest position, abnormal frenum attachment and any swallowing abnormalities.)

▶ Habits (Tongue, thumb, finger and lip habits are often the cause of orthopedic and orthodontic abnormalities. Recognizing their existence can directly affect the success of appliance therapy.) Describe:

▶ TMJ (Bruxism, grinding, abnormal popping, clicking and crepitus are all signs and symptoms of an unhealthy TMJ. It is essential to do a complete examination and report any abnormal findings.) Describe: