

General Information

Doctor's Name: _____ Doctor's Email: _____

Patient's Name: _____ Gender: M F Date of Birth: _____

Present Clinical Condition

Patient's Chief Complaint: _____

Canine Class Relationship Right _____ Left _____
 Molar Class Relationship Right _____ Left _____
 Upper Midline: Centered Shifted Right _____ mm Shifted Left _____ mm
 Lower Midline: Centered Shifted Right _____ mm Shifted Left _____ mm

Instructions (Default options are highlighted in pink)

Treat Arches: Upper Lower
 Maintain Improve Idealize

<input type="checkbox"/> Upper Midline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Midline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overjet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overbite	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Canine Relationship	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Molar Relationship	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Posterior Crossbite	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	If Needed
<input type="checkbox"/> IPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Engagers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Procline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Expand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Distalize	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Instructions: _____

Dr. Signature: _____

Date: _____ License No.: _____

Enclosed Records (Please email photos to photos@smileshapers.com with patient and Doctor names)

Digital Scans PVS Impressions Bite Registration

X-rays:

Pano FMS

Photos:

Face Frontal Smiling
 Right Side in Occlusion (close-up)
 Left Side in Occlusion (close-up)
 Frontal in Occlusion (close-up)

Do not move these teeth:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Avoid engagers on these teeth:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

I will extract these teeth before treatment:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Leave these spaces open:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17