

DATE _____

NAME _____

BIRTHDATE _____

AGE _____

PHYSICIAN'S NAME _____

NICKNAME _____

PHONE _____

1 2 3 4 5 6 7 8 UPPER 9 10 11 12 13 14 15 16

A B C D E F G H I J

RIGHT LINGUAL LEFT

T S R Q P O N M L K

32 31 30 29 28 27 26 25 LOWER 24 23 22 21 20 19 18 17

ech	N	Ab	Tongue	N	Ab	Habits _____	Tooth	Procedure	Code
symmetry			Palate			Cong. Anom. _____			
ph Nodes			Frenum			Evid. of Trauma _____			
osa			Floor of Mouth			Oral Hygiene:			
iva			Tonsils			<input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> good			
			Swallow						

ments: _____

Orthodontic Evaluation

R	L	Spacing _____	O.B. (%) _____	Open bite _____
		Crowding _____	O.J. (mm) _____	Profile _____
		Midline _____	X-bites _____	Space loss _____

ents: _____

ings: _____

ents: _____