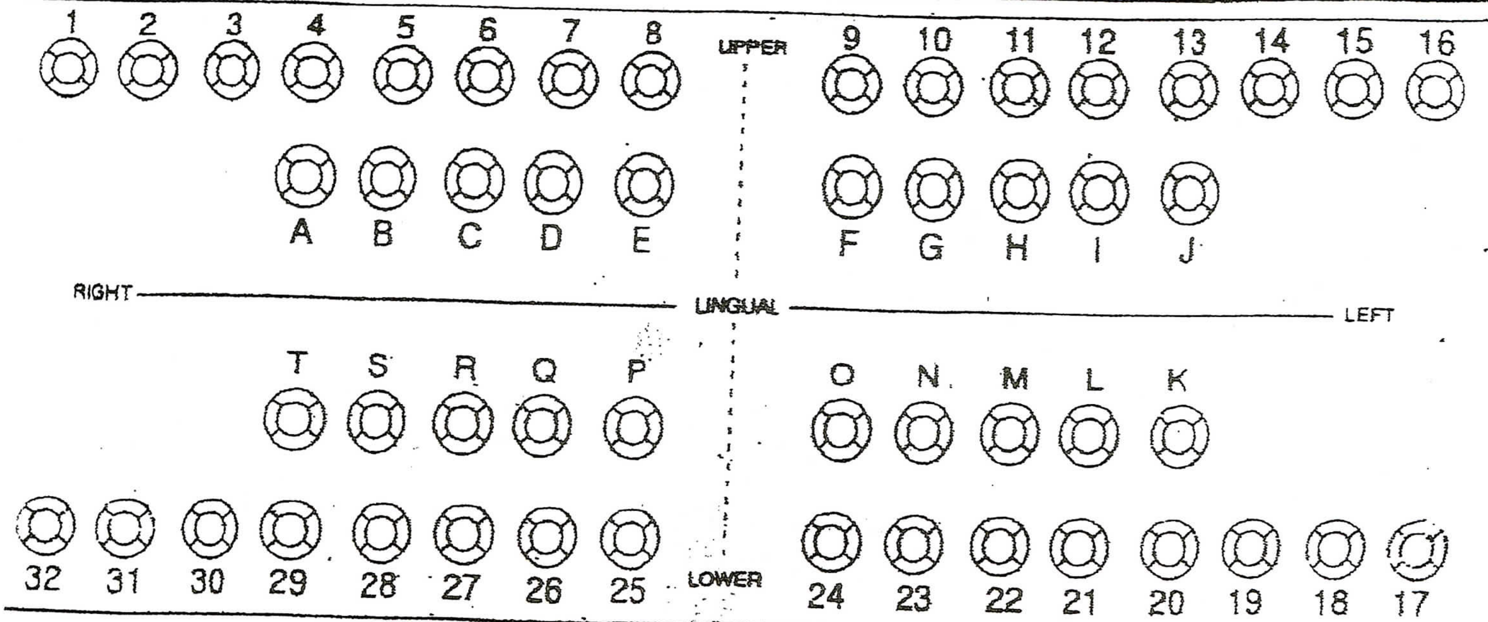
[redacted]

DATE ______________

NAME ______________________________ (__________________) BIRTHDATE ____________ AGE ______

NICKNAME

PHYSICIAN'S NAME ______________________________________ PHONE ____________________



	N	Ab		N	Ab	
ech			Tongue			Habits ____________
. Symmetry			Palate			Cong. Anom. ____________
ph Nodes			Frenum			Evid. of Trauma ____________
			Floor of Mouth			Oral Hygiene:
osa			Tonsils.			☐ poor ☐ fair ☐ good
jiva			Swallow			

ments: ____

Orthodontic Evaluation

R	L

d

Spacing ________ O.B.(%) ________ Open bite ________

Crowding ________ O.J. (mm) ________ Profile ________

Midline ________ X-bites ________ Space loss ________

ents: ____

ings: ____

ents: ____

Tooth	Procedure	Code