

NIHB ORTHODONTIC SUMMARY SHEET

Section 1 Provider Information

Name & Mailing Address/Office Stamp	Prescriber's Telephone
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Section 2 Patient Information

Patient's Name: Surname	Given Name(s)	Date of Birth:	Sex: M _____ F _____
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Oral Hygiene

Chief Complaint: Patient	Chief Complaint: Parent/Guardian
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Skeletal and Soft Tissue/Dental Characteristics

Special Features (Radiographical and Functional Analysis, Periodontal Treatment)

Treatment Objectives

Treatment Plan

Active Treatment Time:

Retention Time:

Cost	Date	Provider's Signature
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I/we understand the nature of the proposed orthodontic treatment and the commitment required should this be approved.

Signature (Parent/Guardian)

Patient