

Day/Night Orthotic Prescription

(416) 630-6262 (800) 410-4392
 www.klauszdentalab.com

Dr. _____ Date _____

Address _____ Phone _____

Patient Name _____ Due Date _____

Please call for consultation

Office Checklist (please initial):

Assistant Initials

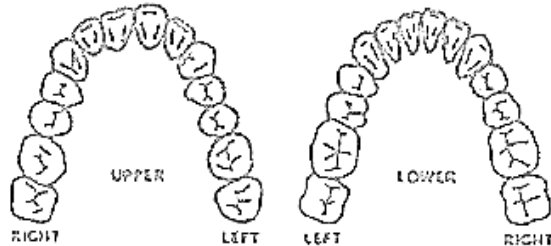
Impressions/Model Accurate: _____
 Hamular Notch Present: _____
 Phonetic Bite Stable & Enclosed: _____
 Lab Prescription Completed: _____

Acculiner Articulation Report:

Maxillary Cant _____ mm	<input type="checkbox"/> Uphill	<input type="checkbox"/> Downhill	<input type="checkbox"/> Anterior	<input type="checkbox"/> Left	<input type="checkbox"/> Right _____ mm
Original CEJ _____ mm			<input type="checkbox"/> Posterior	<input type="checkbox"/> Left	<input type="checkbox"/> Right _____ mm
Dental Midline Md. _____ mm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Skeletal Midline _____ mm	<input type="checkbox"/> Left	<input type="checkbox"/> Right

Indicate Clasp:

Ball (B) _____ per side
 Adams (A) _____ per side
 Other (O) _____ per side



Mandibular Day Appliance

- Mandibular Positioning Appliance
 - PMT Base or Thermoplastic Base
- Compact Mandibular Positioning Appliance
- Pivot Appliance
- Other

Changes from "0"

Vertical + _____ mm (open) - _____ mm (close)
 Mandibular Rotation: _____ mm (Patient) Right Left
 Protrusion _____ mm Retrusion _____ mm
 CEJ's set at _____ mm

Maxillary Night Appliance

- Base PMT Base or Thermoplastic Base
- Anterior Deprogrammer
 - With Lingual Ramp
 - With Open Lingual Ramp
 - With Open Lingual Ramp & Aries Buttons
 - Decompressor (Flat Plane Splint)
 - Other

Changes from "0"

Vertical + _____ mm (open) - _____ mm (close)
 Mandibular Rotation: _____ mm (Patient) Right Left
 Protrusion _____ mm Retrusion _____ mm
 CEJ's set at _____ mm

Notes: _____

Dr. Signature: _____

Date: _____