

Olmos Prescription

Toll Free: (800) 410-4392
Local: (416) 630-6262
www.klauszdentallab.com

Dr. _____ Date: _____ Dr. Signature _____ Lic # _____

Address _____ Phone _____

Patient Name: _____ Due Date: _____ Please call for consultation

Office Checklist (please initial):

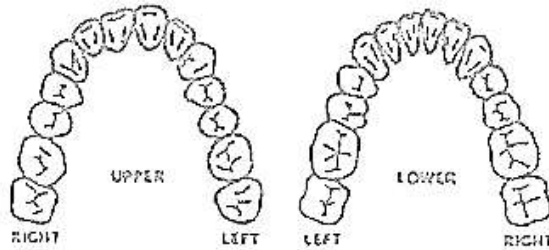
	1st Assistant initials	2nd Assistant Initials
Impressions/Models Accurate:	_____	_____
Hamular Notch Present:	_____	_____
Phonetic Bite Stable and Enclosed:	_____	_____
Lab Prescription Completed:	_____	_____
Pharyngometer Evaluated Bite:	_____	_____

Acculiner Articulation Report:

Maxillary Cant _____ mm Uphill Downhill Anterior Left Right _____ mm
 Original CEJ _____ mm Posterior Left Right _____ mm
 Dental Midline Md. _____ mm Left Right Skeletal Midline _____ mm Left Right

Indicate Clasp:

- Ball (B)
- Adams (A)
- Other (O)



Day Appliance

- Date of Phonetic Bite: _____ No Change
- OD1**(all Acrylic)
 - OD2**compact w/ lingual wire)
 - OD3**(P.M.T w/ Acrylic)
 - Other**

Changes from "0"

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

Night Appliance

- Type of Bite Phonetic Ecovision Other No Change
- Base Acrylic Custom PMT
- ON1** (Anterior Deprogrammer)
 - ON2**(Olmos Night Positioner)
 - ON3**(Olmos Open Air)
 - ON4**(Olmos Decompressor)
 - ON6**
 - 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: _____

