Doing a Diagnosis and writing a Treatment Plan for Team communication…

Each doctor should have an efficient method of diagnosing and treatment planning a patient so that complete treatment may be delivered to the patient. Also, this will facilitate fully informing the patient about the risks and limitations of treatment. This proposed system for diagnosing the problems a patient has and determining the best options for the patient’s treatment organizes all of the data about the patient and facilitates delivery of the treatment in an efficient manner.

The Diagnosis and Treatment Planning Study Packet provides all of the forms for organizing the process. This is an explanation of each step of the process as listed on the Diagnosis and Treatment Planning Checklist.

**Step 1: Gather materials for completing a Diagnosis and Treatment Plan:**
- Chart Folder if creating a paper chart
- Printed Series of Photographs
- Study Models with Bolton Tooth Size Discrepancy Analysis, Arch Length Analysis, Arch Width Analysis, and Arch Symmetry Analysis, Life-size copy of arches to be attached to chart for quick reference of crowding and arch size for coordinating wires
- Cephalometric Film, Tracing, Measurements
- Panorex and Panoramic Analysis
- Periapical and Bitewing Radiographs
- Periodontal Exam Form completed if the patient is an adult
- Patient History and Social information
- Completed New Patient Exam Form
- New Patient Exam Letter that was given to the Patient
- New Patient Exam Letter that was sent to the Dentist
- Financial Options Summary form that was given to the Patient at the New Patient Exam
- Treatment Record with Top Section of the patient information typed in
- Diagnosis Forms and Consult Checklist
- Treatment Plan Sheet
- Financial Consult Sheet
- Risks Consent List

**Step 2: Enter Data onto the Treatment Record.**
As you enter the data on the Treatment Record and Consult Checklist, make a mental list of the problems and potential solutions. These will be written in Step 3.
1. History and Social Notes
2. Alerts in Box
3. Facial Evaluation
4. TMJ Notes
5. Soft Tissue, Frenum, Recession, Periodontal Problems in the Alerts Box
6. Note Molar and Canine Class in Millimeters as Measured off of the Models
7. Note Overjet
8. Cephalometric Measures Noted
9. Midlines
10. Crossbites and Arch Form
11. Overbite, Openbite Areas, and Tongue Position
12. Arch Length
13. Bolton Tooth Size Discrepancy
14. Molar and Canine Symmetry
15. Missing Teeth including third molars
16. Notes from Panorex

**Step 3: Write a Problem List and Potential Solutions**
In this section list all problems and the potential solutions to those problems.
Step 4: Write a Brief Diagnosis.
• Succinct and Brief
• What is the Facial Pattern?
• What is the Skeletal Pattern?
• What is the Angle Classification?

Step 5: What are the Treatment Goals
• What was the Patient’s Chief Complaint? Are you addressing it?
• What needs to be done to get Ideal Results?
• What needs to be done to get Compromised Results?

Step 6: Write down all Treatment Options and their Advantages and Disadvantages
• Treatment Options
  o Extraction/Non-extraction
  o Growth Appliance/Surgical Correction
  o TADs
  o Cooperation Dependent
  o No Treatment
• Possible Advantages
  o Shortest treatment time
  o Best occlusion and facial results
  o Not growth dependent
• Possible Disadvantages
  o Surgical risk and expense
  o Loss of 4 teeth
  o Unstable result

Step 7: Write and Type a Final Treatment Plan as described on a separate document

Step 8: Communicate with the General Dentist and Interdisciplinary Team
Step 9: Communicate with other professionals

Step 10: Complete the Consult Checklist to be used in the Treatment Consult
• Estimate Treatment Length
• Complete Fee estimate

Step 11: Complete the Consult Summary Excel Spreadsheet with Fee explanation
Step 12: Complete the Potential Treatment Risks List specifying which risks are especially relevant
1. Gather materials for completing a Diagnosis and Treatment Plan:
   - Chart Folder
   - Printed Photographs
   - Study Models with Bolton Evaluation and Photo Copy of Arches
   - Cephalometric Film, Tracing, Measurements
   - Panorex
   - Periapical and Bitewing Radiographs
   - Periodontal Exam Form
   - Patient History and Social information
   - Completed New Patient Exam Form
   - New Patient Exam Letter to the Patient
   - New Patient Exam Letter to the Dentist
   - Financial Options Summary
   - Treatment Card with Top Section Typed In
   - Diagnosis Form and Consult Checklist
   - Treatment Plan Sheet
   - Financial Consult Sheet
   - Risks Consent List

2. Enter Data onto the Treatment card.
   1. History and Social Notes on the Treatment Card
   2. Alerts in Box
   3. Facial Evaluation
   4. TMJ Notes
   5. Soft Tissue, Frenum, Recession, Periodontal Problems in the Alerts Box
   6. Note Molar and Canine Class in Millimeters as Measured off of the Models
   7. Note Overjet
   8. Cephalometric Measures Noted
   9. Midlines
   10. Crossbites and Arch Form
   11. Overbite, Openbite Areas, and Tongue Position
   12. Arch Length
   13. Bolton
   14. Molar and Canine Symmetry
   15. Missing Teeth
   16. Notes From Panorex
3. Write a Problem List.
   - Social, Medical, and Dental History
   - Growth
   - Facial Pattern
   - Anterior Posterior Relationships
     - Skeletal
     - Angle Classification
   - Transverse Relationships
     - Skeletal
     - Dental
   - Vertical Relationships
     - Skeletal
     - Dental
   - Perimeter Factors
   - Periodontal Factors
   - TMJ Factors

4. Write a Brief Diagnosis.
   - Succinct and Brief
   - Facial Pattern
   - Angle Classification

5. Determine Treatment Goals
   - Patient’s Chief Complaint
   - Ideal Results
   - Compromised Results

6. Determine Treatment Options and their Advantages and Disadvantages
   - Possible Advantages
     - Shortest treatment time
     - Best occlusion and facial results
     - Not growth dependent
   - Possible Disadvantages
     - Surgical risk and expense
     - Loss of 4 teeth
     - Unstable result

7. Write and Type a Final Treatment Plan
   - Label paper
   - 8 point font

8. Communication with the General Dentist

9. Communicating with Other Professionals

10. Completion of the Consult Checklist
    - Estimating Treatment Length
    - Fee Schedule

11. Completion of the Financial Presentation Sheet

12. Completion of the Potential Treatment Risks Sheet
Name: 
Exam Date: M/D 
Age: 

Dentist: 
Records: 
Age: 

CC: 
Attitude: 
Time/Moving Pbs: 

Med Hx: 
Growth: 
Dent Hx: 

<table>
<thead>
<tr>
<th>Teeth: Primary, mixed, permanent, missing</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Pan date:</th>
<th>Resorp:</th>
<th>Root shape:</th>
<th>Leew:</th>
<th>Full erupt:</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TMJ: OK</th>
<th>7’s year</th>
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<tbody>
<tr>
<td>8 8</td>
<td>Other:</td>
</tr>
<tr>
<td>8 8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DX: Class Dental:</th>
<th>Skeletal:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TREATMENT OBJECTIVES**

1. Skeletal Class Dental Class OJ Ideal 2-2
2. Level to ideal OB 2-2
3. Align
4. Transverse: Widen ↑ ↓ MLs on
5. 

**TREATMENT ALTERNATIVES**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consult Date:</th>
<th>Init</th>
<th>Present: M D P</th>
<th>Init</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Req: X</td>
<td>Fluoride Rx/Peridex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ext. of Teeth 8 8 Soon</td>
<td>Retention: Hawleys ↑ ↓ Clear ↑ ↓ Bonded ↑ ↓ X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 8 Later</td>
<td>Sulcus Slice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Care X</td>
<td>Frenectomy ↑ La ↓ La Li</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Hygiene X</td>
<td>Gingivoplasty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet &amp; Appl. Care X</td>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coop: HG, EXP, CBJ, EL X</td>
<td>Bolton</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacations X</td>
<td>Perio: Gingivitis Recession Bulk X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retainers X</td>
<td>Resorption X</td>
<td></td>
<td></td>
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<tr>
<td>Appointments X</td>
<td>Decalcification Present</td>
<td></td>
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<tr>
<td>Broken Appointments X</td>
<td>Restorative</td>
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</tr>
<tr>
<td>Emergency Number X</td>
<td>TMJ X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results Anticipated: 1 = great  2 = good  3 = limited

Limitations

<table>
<thead>
<tr>
<th>Facial / Skeletal Result</th>
<th>Foster Overall Positive Self-image</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Dental and Smile Result</td>
<td>Shortest Treatment Time</td>
</tr>
<tr>
<td>Optimal Occlusal Result</td>
<td>Minimal Discomfort</td>
</tr>
<tr>
<td>Optimal TMJ and Myofacial Result</td>
<td>Noncompliance Biomechanics</td>
</tr>
<tr>
<td>Optimal Perio Health</td>
<td>Cooperation Dependent</td>
</tr>
<tr>
<td>Optimal Stability</td>
<td>Growth Dependent</td>
</tr>
</tbody>
</table>
### Diagnosis and Treatment Planning Worksheets

**Patient Name ____________________________________________ Date __________________________**

#### Write a Problem List

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social, Medical, and Dental History</td>
<td></td>
</tr>
<tr>
<td>Growth</td>
<td></td>
</tr>
<tr>
<td>Facial Pattern</td>
<td></td>
</tr>
<tr>
<td>Anterior Posterior Relationships</td>
<td></td>
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<tr>
<td>– Skeletal</td>
<td></td>
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<tr>
<td>– Growth direction</td>
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<tr>
<td>– Angle Classification</td>
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<tr>
<td>Transverse Relationships</td>
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<td>– Skeletal</td>
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<td>– Dental</td>
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<tr>
<td>Vertical Relationships</td>
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<tr>
<td>– Skeletal</td>
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<tr>
<td>– Dental</td>
<td></td>
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<tr>
<td>Perimeter Factors</td>
<td></td>
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<tr>
<td>Periodontal Factors</td>
<td></td>
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<tr>
<td>TMJ Factors</td>
<td></td>
</tr>
</tbody>
</table>

#### Write a Brief Diagnosis

- Facial Pattern
- Skeletal Pattern
- Angle Classification

#### Determine Treatment Goals

**Ideal Results**

1. Skeletal Class | Dental Class | OJ Ideal | 2-2
2. Level to ideal OB | | 2-2
3. Align | |
4. Transverse: Widen ↑↓ MLs on | |
5. | |

**Compromised Results**

1. Skeletal Class | Dental Class | OJ Ideal | 2-2
2. Level to ideal OB | | 2-2
3. Align | |
4. Transverse: Widen ↑↓ MLs on | |
5. | |
## Determine Treatment Options and their Advantages and Disadvantages

<table>
<thead>
<tr>
<th>TREATMENT OPTION</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</table>
Writing a Treatment Plan to be a form for Team communication…

A Treatment Plan can be an effective form of communication with the entire orthodontic team. To do this it should be written with some detail and then each team member should be taught to read it. In orthodontics, there is no standard format that is used for writing a Treatment Plan. The method proposed here was used in private practice successfully for 25 years.

The form below should be used by the orthodontist to select the procedures that need to be done to deliver the treatment to the patient. After the orthodontist completes the form, it is typed and entered on the Treatment Record or into the Patient Management software program of the computer so it can be viewed easily at each appointment. As the Treatment Plan is followed, each step should be checked off or highlighted as completed.

Section 1:
Name_________________________ Class _________ Phase I II C Lmt No. mos. _________
• Name: Enter the name of the patient.
• Class: Enter the Angle Class of the patient.
• Phase: Enter the Phase of treatment: Phase I, Phase II, C for Comprehensive, Lmt for Limited treatment such as retreatment.
• No. mos.: Enter the number of months the treatment is estimated to take.

Section 2:
Retakes: Photos: EO EOS EOP Sm RIO FIO LIO Mx Md PA’s: 21 12 2-2 VBWS FMS PANO and have Dr.check____________
Ceph Ceph measures
• Circle the photos that need to be retaken:
  o EO-Extraoral Serious, EOS-Extraoral Smiling, EOP-Extraoral Profile, Sm-Close-up Smile, RIO-Right Intraoral, FIO-Frontal Intraoral, LIO-Left Intraoral, Mx-Maxillary Occlusal, Md-Mandibular Occlusal
• Circle the PAs or periapical radiographs 21 12 2-2 that need to be taken such as maxillary and mandibular incisors, VBWS-vertical bite wings, FMS-Full Mouth Series of radiographs, PANO-panoramic radiograph, and have Dr.check-and have the doctor check the radiograph that there are no findings that should be noted.
• Circle Ceph if the ceph headfilm needs to be retaken and circle Ceph measures if the ceph headfilm needs to be remeasured.
• Circle Perio exam if a periodontal exam needs to be done.
• Circle Models: Check bite/Retrim- if the bite registration needs to be done or if the models need to be retrimmed, circle Relabel if the models need to be relabeled, circle Do Bolton if a Bolton Analysis needs to be done on the models

Section 3:
Brackets to use: _______ __________ Self-Ligating Clear
• Indicate the brackets that are to be used with the patient such as MBT, self-ligating, clear, or others
Section 4:

Imp for BB  BB depth/OJ ________  Place seps ______________

- Circle Imp for BB if an anterior impression has to be taken if anterior bite buttons made of Triad material will be placed on the maxillary central incisors. Indicate the amount of overjet so the lab knows the depth to make the bite buttons.
- List in Place seps ______________ any teeth that will need seps placed before an impression for a fixed appliance.

Section 5:

Imps for:  Mays Hyrax  Hyrax  Quad Helix  CBJ ________________

PHA  LLA  Pendex  E-arch  Other: ________________

Resep ________________

- Circle if an impression for an appliance has to be done for a specific appliance.
- Write in any tooth numbers of teeth that need to be reseparated after the impression.

Ext ___________ When? ______________________

- Write in the tooth numbers or letters of any teeth that need to be extracted.
- Write in the date when teeth should be extracted (such as before or after appliance placement).
- Note if third molars are to be extracted and when.

Section 6: The Treatment Plan

Mx  

List next wire size  

Md  

List next wire size  

- Write under Mx the teeth that are to be bonded and banded in the Maxillary arch and the initial wire size, then the next wire size, and the size after that.
- Write under Md the teeth to be bonded and banded in the Mandibular arch and the initial wire size and progression of wires.
- List in the center any headgear or other appliances to be placed.
- Write in the center if any special procedures are going to be done such as frenectomies, gingivoplasties, crowns, restorative such as veneers on small laterals, implants, or other interdisciplinary treatment.
- Note any Long or Short Tie Backs, Note open or closed Coil Springs, Note any brackets to be ADDed on such as adding 7s when they erupt, Note Elastics to be worn, Note HG to be worn, Note Lingual buttons for elastics or rotations.

Section 7:

Reassess in Phase I Tx or Limited Tx
Deband/Retainers/Recall

- If the treatment is Phase I or Limited Treatment, then the patient should be reassessed with Photos and a Progress Exam, possibly a Cephal and Panorex.
- The progress records should be worked up and a Progress Consult done to review what has been accomplished with treatment, and a decision made to deband, place retainers, recall, or go into Phase II.
- Then the patient should be scheduled for a debanding, placement of retainers, and recall.
Section 8:

**Comprehensive Tx or Phase II Tx:**

- Detailing Appts
- Deband Checks
- Deband/Final Records

**Types of Retainers to be used**
Bonded, Hawleys, Clear

**Bleaching**

**Referral for Post-tx procedures**

**Post-treatment Consult**

**Retention Phase**

- If the patient is Comprehensive Treatment or Phase II Treatment, then the patient should have a Detailing appointment with a panoramic radiograph done, Deband Check Appointments, and the Debanding.
- The types of retainers that will be used should be planned in the Treatment Plan so that bonded retainers can be placed at the debanding.
- All final records should be taken the day of the debanding.
- A Post-Treatment Consult checklist should be done at the debanding that will communicate with the dentist that treatment has been completed.
- Bleaching should be planned if this will be done.
- Referral for post-treatment procedures should be specified.
- The need for a Post-Treatment Consult should be planned.

After the Treatment Plan is written by the orthodontist it should be typed and entered on the Treatment Record or entered in the computer and followed at each appointment. As treatment is delivered the Treatment Plan should be highlighted for what has been done so it can be seen easily what is to be done next.

If the patient’s treatment is dramatically changed, the Treatment Plan should be updated. For instance, if the patient has already completed Phase I and is going into Phase II, a new Treatment Plan should be written and guide the new treatment.
TX Plan:

1. Name_________________________________ Class _________ Phase I II C Lmt No. mos. _________

2. Retakes: **Photos:** EO EOS EOP Sm RIO FIO LIO Mx Md
   **PA’s:** 21 12 2-2 VBWS FMS PANO and have Dr.check_____________
   Ceph Ceph measures

   Perio exam
   Models: Check bite/Retrim Relabel Do Bolton

3. Brackets to use: _______ _______ Self-Ligating Clear

4. ↑Imp for BB BB depth/OJ _______ Place seps ______________

5. Imps for: Mays Hyrax Hyrax Quad Helix CBJ________________
   PHA LLA Pendex E-arch Other: ________________
   Resep _______________ Ext _______________ When? ________________

6. **Mx**
   Bond which teeth, Band which teeth, list wire size to use
   List next wire size
   List next wire size

   **Md**
   Bond which teeth, Band which teeth, list wire size to use
   List next wire size
   List next wire size

7. Reassess in Phase I Tx or Limited Tx
   Deband/Retainers/Recall

8. Comprehensive Tx or Phase II Tx:
   Detailing Appts
   Deband Checks
   Deband/Final Records
   Types of Retainers to be used Bonded, Hawleys, Clear
   Bleaching
   Referral for Post-tx procedures
   Post-treatment Consult
   Retention Phase

**NOTE:**
<2/2
Long/Short TB
Coil Spring
ADD on
Elastics
HG
Lingual buttons
COMPREHENSIVE TREATMENT

Patient: ________________________      Age: ____ years ____ months     Date:_____________

The doctor has completed an analysis of the orthodontic records and has found the following areas of concern:

___Overbite   ___Underbite
___Jaw relationship problem: ___lower jaw underdeveloped
___upper jaw underdeveloped
___lower jaw overdeveloped
___Expected jaw growth limited or unfavorable direction
___Crossbite   ___Arch constriction or narrow arch form
___Back teeth not lined up
___Midline shift   ___Asymmetry
___Excessive gum showing with smiling
___Openbite   ___Tongue thrust habit
___Excessively deep bite   ___Wear of teeth
___Crowding of the teeth   ___Spacing of the teeth
___Rotations of the teeth or malalignment
___Missing teeth   ___High root resorption potential
___Oral hygiene   ___Gum concerns: ___frenum   ___recession   ___bulk
___TMJ signs or symptoms or history of problems
___Other  _____________________________________________________________

The doctor’s treatment recommendations are:

___Comprehensive-Full Orthodontic Treatment with
   ___Full braces
   ___Headgear: Type:___________________ Hours:_________________
   ___CBJ Growth Appliance
   ___Expansion
   ___Palatal holding arch   ___Lower lingual arch
   ___Habit appliance:___________________   ___Bite buttons
   ___Extraction of teeth:
   ___Frenectomy, gingivoplasty, gingival graft, or other periodontal therapy
   ___Elastics
   ___Other:
   ___One set of retainers and supervision of retention for two years

Anticipated limitations of treatment are:_______________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

The anticipated length of this treatment is _______ months and the treatment fee is $___________________
which can be paid:

1. With a downpayment of $__________________ and a contract for ______ months for $____________ per month.

2. With a 6% reduction of the fee for payment in full at the beginning of treatment by either cash or check. Fee reduction is $_________________ for a total of $___________________.

3. With a 3% reduction of the fee for payment in full at the beginning of treatment by credit card. Fee reduction is $_________________ for a total of $_________________.

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PHASE I TREATMENT

Patient: ______________________  Age: ___ years ___ months  Date: ______________

The doctor has completed an analysis of the orthodontic records and has found the following areas of concern:

___ Overbite  ___ Underbite
___ Jaw relationship problem: ___ lower jaw underdeveloped
                      ___ upper jaw underdeveloped
                      ___ lower jaw overdeveloped
___ Expected jaw growth limited or unfavorable direction
___ Crossbite  ___ Arch constriction or narrow arch form
___ Back teeth not lined up
___ Midline shift  ___ Asymmetry
___ Excessive gum showing with smiling
___ Openbite  ___ Tongue thrust habit
___ Excessively deep bite  ___ Wear of the teeth
___ Crowding of the teeth  ___ Spacing of the teeth
___ Rotations of the teeth or malalignment
___ Missing teeth  ___ High root resorption potential
___ Oral hygiene  ___ Gum concerns: ___ frenum ___ recession ___ bulk
___ TMJ signs or symptoms or history of problems
___ Other _______________________________________________________

The doctor’s treatment recommendations are:

___ Phase I-Early Orthodontic Treatment which will consist of:

  ___ Limited braces
  ___ Headgear: Type __________________________ Hours: _______
  ___ CBJ Growth Appliance
  ___ Expansion
  ___ Palatal holding arch  ___ Lower lingual arch
  ___ Habit appliance: _________  ___ Bite buttons
  ___ Extraction of teeth:
  ___ Frenectomy, gingivoplasty, gingival graft, or other periodontal therapy
  ___ Other _______________________________________________________
  ___ Temporary retainer(s)
  ___ Supervision until full eruption of the teeth
  ___ Phase II (full orthodontic treatment) may be needed in the future

Anticipated limitations of treatment are:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The anticipated length of this treatment is _______ months and the treatment fee is $__________, which is paid with a downpayment of $_______ and a contract for _______ months for $_________ per month. The fee can also be paid in full at the beginning of treatment, or with an alternative payment plan.
PHASE II TREATMENT

Patient: ________________________      Age: ____ years ____ months      Date:_____________

The doctor has completed an analysis of the orthodontic records and has found the following areas of concern:

___Overbite   ___Underbite
___Jaw relationship problem: ___lower jaw underdeveloped
___upper jaw underdeveloped
___lower jaw overdeveloped
___Expected jaw growth limited or unfavorable direction
___Crossbite   ___Arch constriction or narrow arch form
___Back teeth not lined up
___Midline shift   ___Asymmetry
___Excessive gum showing with smiling
___Openbite   ___Tongue thrust habit
___Excessively deep bite   ___Wear of teeth
___Crowding of the teeth   ___Spacing of the teeth
___Rotations of the teeth or malalignment
___Missing teeth   ___High root resorption potential
___Oral hygiene   ___Gum concerns:___frenum   ___recession   ___bulk
___TMJ signs or symptoms or history of problems
___Other

The doctor's treatment recommendations are:

___Phase II-Full Orthodontic Treatment with
   ___Full braces
   ___Headgear: Type:___________________ Hours:_________________
   ___CBJ Growth Appliance
   ___Expansion
   ___Palatal holding arch              ___Lower lingual arch
   ___Habit appliance:_______________________  ___Bite buttons
   ___Extraction of teeth:
   ___Frenectomy, gingivoplasty, gingival graft, or other periodontal therapy
   ___Other:
   ___One set of retainers and supervision of retention for two years

Anticipated limitations of treatment are:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The anticipated length of this treatment is _______ months and the treatment fee is $___________________ which can be paid:

1. With a downpayment of $__________________ and a contract for _____ months for $____________ per month.

2. With a 6% reduction of the fee for payment in full at the beginning of treatment by either cash or check. Fee reduction is $_________________ for a total of $_________________.

3. With a 3% reduction of the fee for payment in full at the beginning of treatment by credit card. Fee reduction is $_________________ for a total of $_________________.

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TREATMENT RECOMMENDATIONS AFTER A PROGRESS EVALUATION

Patient: ___________________________  Age: ___years ___months  Date: ____________

The doctor has completed a review of progress to date and has found the following areas of continued concern:

- Overbite
- Underbite
- Jaw relationship problem: lower jaw underdeveloped
- upper jaw underdeveloped
- lower jaw overdeveloped
- Expected jaw growth limited or unfavorable direction
- Back teeth not lined up
- Crossbite
- Arch constriction or narrow arch form
- Midline shift
- Asymmetry
- Excessive gum showing with smiling
- Openbite
- Excessively deep bite
- Crowding of the teeth
- Spacing of the teeth
- Rotations of the teeth or malalignment
- Missing teeth
- High root resorption potential
- Oral hygiene
- Gum concerns: frenum recession bulk
- TMJ signs or symptoms or history of problems
- Other

The doctor's treatment recommendations are:

- Deband, temporary retention, and recall until full eruption
- Extention of Phase I-Limited treatment
- Phase II-Full Orthodontic Treatment

This treatment would include:

- Full braces
- Herbst
- Headgear
- Bionator
- Expansion
- Palatal holding arch
- Lower lingual arch
- Habit appliance: Bite buttons
- Extraction of teeth:
- Frenectomy, gingivoplasty, gingival graft, CFR, or other periodontal therapy
- Other:
- Orthognathic surgery
- One set of retainers, with supervision of retention for two years.

Anticipated limitations and considerations of treatment are:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The anticipated length of this treatment is _____ months and the treatment fee is $____________, which can be paid with a downpayment of $____________ and a contract for _____ months for $____________ per month.
### LIST OF POSSIBLE RISKS RESULTING FROM ORTHODONTIC TREATMENT AND LIMITATIONS OF TREATMENT

_____ Fracture of a tooth due to large fillings

_____ Fracture of tooth due to eating hard foods or trauma

_____ Desired skeletal correction not achieved due to:
   ____ Lack of patient cooperation
   ____ Lack of growth
   ____ Lack of growth in proper direction
   ____ Other:

_____ Other:

_____ Desired bite not achieved due to:
   ____ Ankylosis of teeth fused to the bone
   ____ Lack of patient cooperation
   ____ Tooth-size problems
      ____ Primary molars present without permanent teeth to replace them
      ____ Small lateral incisors, need to enlarge/widen teeth
      ____ Large lateral incisors
      ____ Other tooth size problems
   ____ Other:

_____ Decalcification and decay due to:
   ____ Poor oral hygiene
   ____ Eating foods/drinks high in sugar
   ____ Lack of dental cleanings at 3-6 month intervals with wires removed

_____ Root canal therapy flare ups

_____ Tooth nerve death with darkening of the tooth from unknown cause requiring root canal therapy

_____ Gingivitis/Periodontitis with irreversible bone loss due to
   ____ Poor oral health
   ____ Other:

_____ Gum “bunching” due to fibrous gum tissue

_____ Gum recession

_____ Root resorption, or excessive root shortening, which decreases the support of the teeth from
   ____ Canines
   ____ Trauma
   ____ Unknown cause

_____ Increased need for restorative treatment
   ____ Enlarge upper laterals
   ____ Other:

_____ Sinus preventing movement of upper back teeth

_____ TMJ concerns and problems
   ____ Hormonal changes
   ____ Stress
   ____ Bruxism/clenching
   ____ Other or unknown cause
____ Lack of stability of position of teeth (relapse) after the braces are removed
____ Unexpected impaction of teeth
____ Slow eruption of the teeth
____ Longer than anticipated treatment time due to ____________________________________________________________
____ Need for orthognathic surgery due to ________________________________________________________________
____ Other: ______________________________________________________________________________________

These risks have been discussed with me by Dr. ________________ or one of the staff. I am willing to undergo orthodontic treatment understanding these risks or limitations of treatment.

________________________________________________________ _______________________________________
Signature of patient/parent Date