ORTHODONTIST'S REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH SERVICES
SFN 762 (Rev. 09-2009)

NOTE TO ORTHODONTIST: This report is needed to determine eligibility for handicapping malocclusion but is not needed for malocclusion related to cleft lip and/or palate. CSHS does not require the Prior Treatment Authorization Request (PTAR) form.

Clear Fields

Patient:			Date of Birth:
Parent:			
Address:	City:	State:	ZIP Code:

1. PROCEDURE INSTRUCTIONS (For Completing Item Number 2 Below)

a. Occlude patient or models in centric position.

b. Record all measurements in the order given and round off to the nearest millimeter.

c. Start by measuring OVERJET of the most protruding incisor.

d. Measure OVERBITE from the labio-incisal edge of overlapped front tooth or teeth to point of maximum coverage.

e. ANTERIOR ECTOPIC ERUPTION and ANTERIOR CROWDING; DO NOT DOUBLE SCORE.
Record the most serious condition and follow your first impression.

2. CONDITIONS OBSERVED

		SCORE
a. Overjet in mm		
b. Overbite in mm		
c. Mandibular protrusion in mm (refers to Classic Class III case only)	X 5	
d. Anterior open bite in mm	X 4	
e. Ectopic eruption, anteriors only, each tooth Anterior crowding: maxilla _____ mandible _____ Score 5 points per arch regardless of the degree of crowding. (Maximum score this item is 10 points.)	X 3 **OR**	
f. Labiolingual spread in mm (refers to any spaces between anterior teeth measured in mm from mesial of left cuspid to mesial of right cuspid, each arch)		
	TOTAL	

3. ESTIMATED COST AND LENGTH OF CARE

a. Full fee

b. Initial fee

c. Monthly fee

d. Expected Length of Treatment

4. COMMENTS

Signature of Orthodontist:	Printed Name of Orthodontist:	Date:

DISTRIBUTION: Submit original to Children's Special Health Services. Retain a copy for your records.