



Patient: \_\_\_\_\_

Dentist: \_\_\_\_\_

**PROTRUSIVE BITE**

- Bite represents maximum (100%) of protrusion
- Bite represents starting point

**VERTICAL DIMENSION**

- Close as needed
- Keep it, call if changes needed

**LATERAL DEVIATION**

- None
- Yes

**BRUXISM**

- None
- Light-moderate
- Severe

Signature: \_\_\_\_\_

**PLATEAU (Check one upper & one lower)**

<input type="checkbox"/> STANDARD 	<input type="checkbox"/> FULL 	<input type="checkbox"/> ANTERIOR 	COMPLETE if anterior is checked  WIDTH Central only <input type="checkbox"/> Lateral to lateral <input type="checkbox"/> Canine to canine <input type="checkbox"/>
<input type="checkbox"/> STANDARD 	<input type="checkbox"/> FULL 	<input type="checkbox"/> ANTERIOR 	

**BAND (Check one upper & one lower)**

<input type="checkbox"/> SIMPLE BUCCAL <small>recommended</small> 	<input type="checkbox"/> 3/4 	<input type="checkbox"/> SIMPLE LINGUAL 	<input type="checkbox"/> FULL 
<input type="checkbox"/> 3/4 <small>recommended</small> 	<input type="checkbox"/> SIMPLE LINGUAL 	<input type="checkbox"/> SIMPLE BUCCAL 	<input type="checkbox"/> FULL 



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