|  |
| --- |
| **Case No.**  |
| **Patient** | **Name** |  |
| **Sex** | Male / Female |
| **Age** |  |
| **Implant(s) Position** |  |
| **Missing Teeth** |  |
| **First Visit** |  |
| **Implant Surgery** |  |
| **Orthodontic Treatment** |  |
| **Final Restoration** |  |
| **First Recall** |  |
| **Chief Complaint** |  |
| **Implant & Ortho Materials** |  |
| **Case Outline** |  |
| **Treatment Plan** |  |
| **Treatment** |  |
| **Conclusion** |  |

Please add “before and after” pictures. Each cases should list up more than

6 pictures. If additional space is needed, attach on a separate sheet of paper.

|  |
| --- |
| **Pictures** |
|  |  |
| Date : DD/MM/YYNote :  | Date : DD/MM/YYNote :  |
|  |  |
| Date : DD/MM/YYNote : | Date : DD/MM/YYNote : |
|  |  |
| Date : DD/MM/YYNote : | Date : DD/MM/YYNote : |