|  |  |  |
| --- | --- | --- |
| **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/YY  Note : | Date : DD/MM/YY  Note : |
|  |  |
| Date : DD/MM/YY  Note : | Date : DD/MM/YY  Note : |
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