BITE MANAGEMENT SHEET

Doctor: ________________________Patient: ___________________________

Initial Date of NM Treatment: ______________________________________

Teeth or Land Mark for Measurements:	Anterior #:	Posterior Right #:	Posterior Left #:

If land marks, Doctor please mark model with dots!

DR.	Original CO bite Date:			
DR.	NM Bite Registration Date:			
LAB	Removable Orthotic Date:			
DR.	Transfer Bite Date:			
LAB	Fixed Orthotic Date:			
DR.	Transfer Bite Date:			
LAB	Bite Stint/Diagnostic Wax-up Date:			
DR.	Final Relined Bite Stint Pre op & after relining Date:			
DR.	Temporaries Date:			
LAB	Mounting Check Date:			
LAB	Final Restorations on Model Date:			
DR.	Final Check IntraOral Date:			
DR.	Tissue recontouring yes/ no & indicate which teeth			