Diagnosis and Treatment Plan

Patient Name: Date: Treating Doctor Name:

Health History Completed? Yes □ No □ Date: Doctor Initial:

Dental / Head and Neck Examination Completed? Yes □ No □ Date: Doctor Initial: Informed Consent Completed? Yes □ No □

* K03.0 Excessive attrition
* K03.81 Cracked tooth
* K06.0 Gingival recession
* M26.00 Anomalies of jaw size
* M26.12 Maxillary asymmetry
* K08.109 Loss of teeth
* M26.9 Dentofacial anomalies
* K13.0 Diseases of lips
* S01.551 Cheek/Lip biting
* K08.419 Loss of teeth trauma
* M26.12 Jaw asymmetry
* M26.50 Dentofacial abnormal funct
* Other
* Other
* Other

**Muscle** **Filler** **Volume** **Used** **Used** **ml**

|  |  |  |
| --- | --- | --- |
| **(R)** **Nasolabial** **Fold** |  |  |
| **(L)** **Nasolabial** **Fold** |  |  |
| **(R)** **Marionette** **Line** |  |  |
| **(L)** **Marionette** **Line** |  |  |
| **Upper** **Lip** |  |  |
| **Lower** **Lip** |  |  |
| **(R)** **Oral** **Comm** |  |  |
| **(L)** **Oral** **Comm** |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Total** **volume** **used**:

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