Purpose: To be able to convey the big picture in a few sentences. You may need to do this over the phone to a general dentist, so do not speak in a foreign tongue. Use terminology that every dentist can understand. Try not to use numbers, but instead use descriptive terms (for example: instead of saying "9 mm overjet" say "large overjet"). This will get the point across more easily. **This is only when you talk to General Dentists, not to other colleagues.**

If you follow this template you can't go wrong:

Crookedteeth is a _____ yr _____ mo old **ethnic type** **male/female** who presents to the College of Dentistry Orthodontic Clinic with the chief complaint of "_____". His medical and dental histories are significant for _____ (including habits).
He presents with (List pertinent soft tissue features; profile, nasiolabial angle, protrusion of lips). Skeletally, he presents with a Class **I/II/III** skeletal pattern with a **normo/hyper/hypo-divergent** mandibular plane. Dentally, his malocclusion is characterized by: Class **I/II/III** molar, and Class **I/II/III** canine relationships, **mild/moderate/severe** (you probably should write amount in mm) maxillary and/or mandibular **crowding/spacing**, overbite of ___ mm (impinging, openbite; extending from tooth ___ to tooth ___), overjet of ___ mm, **protrusion/retrusion** of upper and lower incisors, rotations (mainly first molars), curve of Spee (moderate, deep; in mm), Bolton discrepancy (anterior/overall, which arch), upper and lower midlines, other things like impacted canines, peg laterals, missing teeth, soft tissue problems, CR-CO shift etc.

References: Harvard Postdoctoral Orthodontic Program Notes

Examples:

Daniel K. is a 11 year 11 month old Caucasian male who presents to HSDM Orthodontic Clinic with a chief complaint of "There is an overlap between my upper teeth, and the upper left teeth are out". His medical and dental histories are not significant with an exception of asthma inhaler that was used when needed and a dental trauma to the maxillary front teeth that did not require any treatment a long time ago. His father was treated surgically for Class III skeletal relationship, and his sister is under current orthodontic treatment for Class I malocclusion. Daniel's profile is slightly convex with obtuse nasiolabial angle and thin upper lip. Skeletally, he presents with retrognathic mandible giving him a skeletal Class II relationship. Dentally, he presents with Class II division 1 malocclusion with ½ cusp Class II molar and canine relationships bilaterally, proclined and protruded U/L incisors, 7 mm OJ, 5 mm OB, and tooth 24 is in buccal crossbite. In the lower arch there is 2.5 mm of crowding and there is nearly 1 mm of space in the upper arch. The depth of the curve of Spee is 4 mm, and there is an anterior mandibular Bolton excess of about 1.7 mm and rotations of upper molars and lower premolars.

Jennifer C. is a 10 year and 9 month old Hispanic female who attended to the HSDM Orthodontic Clinic with a chief complaint of "my font teeth are sticking out". Her medical and dental histories are not contributory, and she used to keep the milk bottle in her mouth until age 7. She has a slightly convex profile, protruded upper and lower lip which are incompetent with the lower lip trapped behind the upper incisors, in addition, her mentolabial sulcus is deep. Jennifer has a short anterior lower facial height and a hypodivergent mandibular plane. She presents with a dental Class II division 1 malocclusion (with the molars and canines in full cusp Class II) on a Class II skeletal base (retrognathic mandible). The U/L incisors are proclined and protruded. OJ is 11 mm and OB is 5 mm. There is spacing in the upper arch of 4 mm, rotations, and 1.6 mm anterior maxillary Bolton excess.

Vandana R. is 25 year and 8 month old Indian female who attends to the HSDM Orthodontic Clinic with a chief complaint of “My dentist -a week ago- recommended braces for me for better function”. Her medical and dental histories are not significant, except for the extraction of the four third molars two year ago. Vandana’s profile is straight with everted lower lip, slightly deep mentolabial sulcus, and prominent soft tissue chin. When Vandana smiles, she shows 2 mm of her gingiva. Skeletally, she presents with slightly short mandible in the sagittal plane giving her a skeletal Class II relationship with hypodivergent mandibular plane and normal lower facial height. Dentally, Class II division 2 malocclusion is evident. Molar relationship is ½ cusp Class II on R and ¼ cusp Class II on L, while the canines are in full cusp Class II on R and ¾ cusp Class II on L, and U/L incisors are retroclined and retruded. OJ is 3~4 mm, OB 6 mm, and there is 5 mm and 8 mm of upper and lower crowding respectively. There is an anterior mandibular Bolton excess of 1.2 mm and an overall mandibular Bolton excess of 2.6 mm, with rotations of upper first molars and premolars. The maxillary first premolars are in buccal crossbite, and there is a clinically detectable CR-MIP shift of about 1~2 mm to the right. The maxillary midline is 1 mm to the left of the facial midline, and 2 mm to the left of the mandibular dental midline in MIP.