SHARP Rees-Stealy Medical Centers

Orthognathic Surgery Prior-Authorization Form

Form Instructions

Patient:
- Print form and give to your Dentist/Orthodontist to complete

Dentist/Orthodontist:
- Fax completed form, cephalometric tracings and notes to: UM Dept: 858-636-2265

Patient Information

Full name: _____ Date of birth: _____

To be completed by patient's dentist/orthodontist (document all actual measurements that apply)

Date of measurements: _____

Maxillary/mandibular incisor relationship: Actual measurement: _____ mm

Maxillary/mandibular antero-posterior molar relationship: Actual measurement: _____ mm

Patient has a vertical facial skeletal deformity over 2 SD of published norms: Yes☐ No☐

(Open bite) Vertical overlap of anterior teeth: Actual measurement: _____ mm

(Open bite) Unilateral or bilateral posterior open bite: Actual measurement: _____ mm

Patient has deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch: Yes☐ No☐

(Open bite) Patient has a supraeruption of a dento-alveolar segment due to lack of opposing occlusion creating dysfunction not amenable to conventional prosthetics: Yes☐ No☐

Patient has a transverse skeletal discrepancy over 2 SD of published norms: Yes☐ No☐

Total bilateral maxillary palatal cusp to mandibular fossa discrepancy: Total bilateral measurement: _____ mm

Unilateral discrepancy given normal axial inclination of the posterior teeth: Unilateral measurement: _____ mm

Antero-posterior, transverse or lateral asymmetry with concomitant occlusal asymmetry: Antero-posterior asymmetry: _____ mm or Transverse asymmetry: _____ mm or Lateral asymmetry: _____ mm

Dentist/Orthodontist Information

Name (please print): _____ Date: _____

Signature: _____ Phone: _____

Office contact name: _____