

# SureSmile® Advanced Treatment Discrepancy Report

**Directions:** Please complete this form when results are not as expected. Fax completed form to SureSmile Customer Care at (972) 728-5601 or email to [SureSmile-Customer-Care@dentsplysirona.com](mailto:SureSmile-Customer-Care@dentsplysirona.com). Provide a full set of photos with the latest wire visible and any additional photos necessary to highlight the discrepancy.

## Section 1: Practice/Patient Information

Date:	Practice Name:
Doctor:	Address:
Contact Person:	City, State, Zip Code:
Phone Number:	Patient ID #:

## Section 2: Have you used the progress evaluation checklist to attempt correction?

<input type="checkbox"/> <b>YES</b> , I have used the progress evaluation checklist to attempt correction. Please answer questions 1 and 2 below and complete Sections 3 and 4. Thank you!	<input type="checkbox"/> <b>NO</b> , I have not used the progress evaluation checklist to attempt correction.
1. Findings:	Please attempt correction using the progress evaluation checklist before completing this form.  If you have questions about this process, please contact Customer Care.
2. Results after Modification Wire(s) reached full expression:	

## Section 3: Wire Modification Information

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Was a new 100% wire with modifications ordered?
	Wire type?
	Date wire inserted:

## Section 4: Discrepancy Details/Additional Information

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Was the patient compliant?
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Have anticipated global corrections from your approved treatment plan been achieved?
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Did brackets come loose that required rebonding?
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Was an update scan performed?
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Have the latest wires been inserted for at least six to eight weeks to allow for full expression?
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Is the wire positioned properly?

Select the appropriate tooth	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Buccal/Lingual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occlusal/Gingival	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torque Facial/Lingual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angulation Mesial/Distal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotation Mesial/Distal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

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Occlusal/Gingival	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torque Facial/Lingual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angulation Mesial/Distal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotation Mesial/Distal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

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