Airway-Oriented Orthodontics

Screening & Prior-Auth Form (2025)

Patient: _____ DOB: _____ Date: _____

Phone: _____ Email: _____

STOP-Bang (check): S T O P B A N G

Total boxes checked: ____ (3 or more = at risk)

Intra-Oral Exam

Mallampati: I II III IV Tonsil: 0 1 2 3 4

Tongue scallop: Yes / No Crossbite: Yes / No

CBCT Airway

Pharyngeal volume ____ cm3 Min CSA ____ mm2

Software: _____ Version: ___

Treatment Plan (tick):

[ ] MARPE

[ ] MSE

[ ] MMA surgery

[ ] PSG referral

[ ] Myofunctional therapy

Codes: D9953 D0367 ICD-10 G47.33 Z72.821

Ortho Sig: _____ Sleep MD: _____