

Treatment Center:				
Civic registration number:				
Last name:		First name:		
<input type="checkbox"/> Q36.9		<input type="checkbox"/> Q36.0		
Age at registration:	<input type="checkbox"/> 5 y	<input type="checkbox"/> 10 y	<input checked="" type="checkbox"/> 16 y	<input type="checkbox"/> 19 y <input type="checkbox"/> 1y p-o
Date at registration:				
Examiners name:				
Bone grafting:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		
<i>Score; bone level in the cleft area estimated in relation to the root length of the tooth mesial of the cleft</i>				
Right side:	<input type="checkbox"/> Not applicable	<input type="checkbox"/> 0: Bone missing	<input type="checkbox"/> 1: <3/4	<input type="checkbox"/> 2: >=3/4
Left side:	<input type="checkbox"/> Not applicable	<input type="checkbox"/> 0: Bone missing	<input type="checkbox"/> 1: <3/4	<input type="checkbox"/> 2: >=3/4