

Rx FOR CLEAR ALIGNER DESIGN

GENERAL INFORMATION:

Doctor: _____

Patient: _____

PATIENT INFORMATION

Gender: Male Female

Age: _____

Medications that may affect treatment: _____

Relevant Dental History: _____

PERIODONTAL STATUS

Areas of thin gingival attachment? Yes No

Tooth Number _____

Loss of attachment? Yes No

Tooth Number _____

Do you wish to minimize movement in that area? Yes No

TREATMENT SPECIFICATION

Do you want to align the treatment from 3-3 (anterior only)
5-5 (2nd premolar to 2nd premolar)
7-7 (full arch treatment, add'l fee will apply)

Treatment (see below for details) Upper Esthetic Treatment
Lower Esthetic Treatment

Allow IPR Yes
No

Allow Attachments Yes
No

Midline (mark only if needed)

Midlines. Do you want to? Improve Maintain

Move Upper Left Right
Lower Left Right

ANTERIOR POSTERIOR RELATION

Maintain Upper Lower

Improve Canine Relationship Left Right

Improve Molar Relationship Left Right

ANTERIOR POSTERIOR RELATION

How do you want to level the anterior teeth? Incisal edges
Gingival margins

OVERJET & OVERBITE

Overjet Overbite
Maintain Maintain
Improve Improve

TOOTH SIZE DISCREPANCY

IPR in Opposite Arch
Leave Spaces Open
Distal to Laterals
Distal to Canines

POSTERIOR CROSSBITE

Maintain
Correct Premolars
Correct Molars

ADDITIONAL COMMENTS