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
(molar movements are not allowed)

☐ 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
☐ Maintain
☐ Improve

Overbite
☐ Maintain
☐ 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

**Doctor is solely responsible for the completion and interpretation of x-rays and other diagnostic records.*