

Rx for Clear Aligner Treatment



Doctor: _____

Patient: _____

TREATMENT SPECIFICATIONS

TREATMENT (see below for details) Upper Esthetic Lower Esthetic

ALLOW IPR Yes No

ALLOW INCISOR EXTRACTIONS Yes, Tooth # _____ No

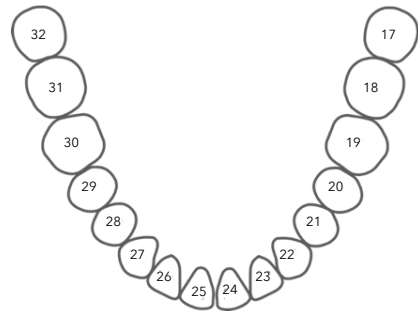
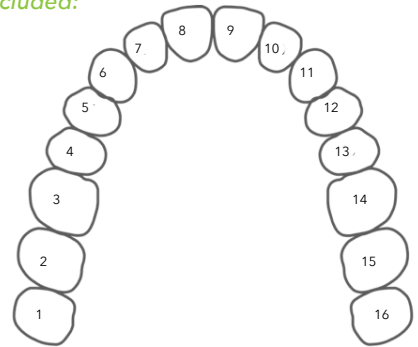
ANKYLOSIS/IMPLANT (tooth not moved) Yes, Tooth # _____ No

MIDLINE (mark only if needed)

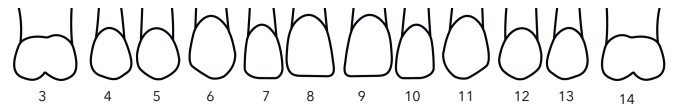
Maintain: Yes, Tooth # _____ No

Move: Upper Left Right Lower Left Right

Specify where IPR is Excluded:



Mark where Attachments are Excluded:



ANTERIOR POSTERIOR RELATION

Maintain: Right Left

Improve Canine Relationship Only:

Right Left

CROWDING

As Needed Primarily

Upper: Expansion IPR

As Needed Primarily

Lower: Expansion IPR

COMMENTS, FURTHER SPECIFICATIONS:

OVERJET & OVERBITE

Overjet Overbite

Maintain Improve

TOOTH SIZE DISCREPANCY

IPR In Opposite Arch

Leave Spaces Open Distal to Laterals Distal to Canines

Van Hook
DENTAL STUDIO

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