Rx for Clear Aligner Treatment

vhaligner the clearer choice

Doctor: _____

Patient: _____

TREATMENT SPECIFICATIONS

TREATMENT (see below for details)
- ☐ Upper Esthetic
- ☐ Lower Esthetic

ALLOW IPR
- ☐ Yes
- ☐ No

ALLOW INCISOR EXTRACTIONS
- ☐ Yes, Tooth # _____
- ☐ No

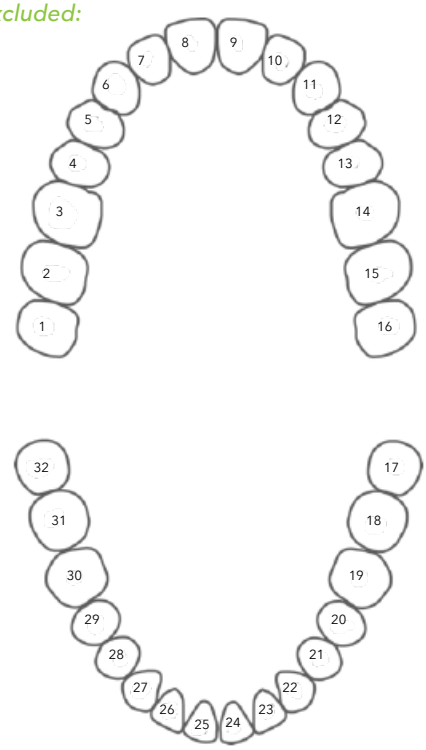
ANKYLOSIS/ IMPLANT (tooth not moved)
- ☐ Yes, Tooth # _____
- ☐ No

MIDLINE (mark only if needed)

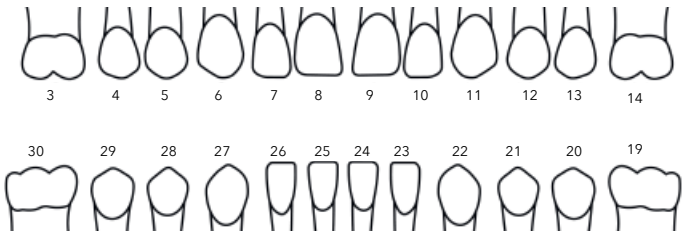
Maintain:
- ☐ Yes, Tooth # _____
- ☐ No

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	☐	☐
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

(480) 730-5998 | vhdental.com