

Rx FOR CLEAR ALIGNER DESIGN

GENERAL INFORMATION:

Doctor: _____

Patient: _____

TREATMENT SPECIFICATION

Do you want to align the treatment from **3-3** (anterior only)
(molar movements are not allowed) **5-5** (2nd premolar to 2nd premolar)

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

Maintain Upper
Lower

Move Upper Left Right
Lower Left Right

ANTERIOR POSTERIOR RELATION

Maintain Upper Lower

Improve Canine Relationship Only 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

ADDITIONAL COMMENTS