Rx FOR CLEAR ALIGNER DESIGN

Sloan DENTAL STUDIO

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
- 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.*