Smile Aligners RX

❖ REQUIRED FIELD

Send completed RX and photos to ortho@classiccraftdental.com

❖ 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	☐ Improve	☐ Maintain
Overbite	☐ Improve	☐ Maintain

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

KEY DENTAL AESTHETICS

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