Priority Smile
SMART CLEAR ALIGNERS

Priority Smile - Smart Clear Aligners Prescriptions

BASIC INFORMATION

Date _____

Doctor's name _____

Patient's name _____

Patient's gender **Patient's date of birth** ____/____/____

Requested Return Date _____ (Allow at least 2 weeks in lab)

INITIAL EXAMINATION DATA

Chief complaint:

Upper midline
centered
shifted right ___ mm
shifted left ___ mm

Lower midline
centered
shifted right ___ mm
shifted left ___ mm

Canine relationship
right: class ___
left: class ___

Molar relationship
right: class ___
left: class ___

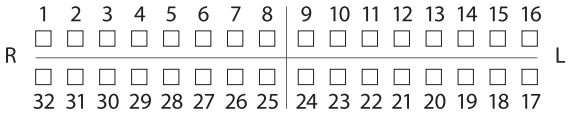
INSTRUCTIONS

Treat arches	upper	lower	
Upper midline	maintain	improve	idealize
Lower midline	maintain	improve	idealize
Overjet	maintain	improve	idealize
Overbite	maintain	improve	idealize
Arch form	maintain	improve	idealize
Canine relationship	maintain	improve	idealize
Molar relationship	maintain	improve	idealize
Posterior crossbite	maintain	improve	idealize

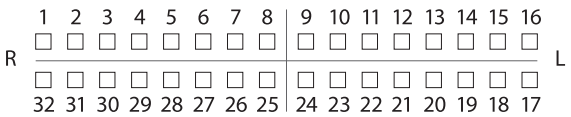
IPR	yes	no	only if needed
Engagers	yes	no	only if needed
Procline	yes	no	only if needed
Expand	yes	no	only if needed
Distalize	yes	no	only if needed

Other instructions:

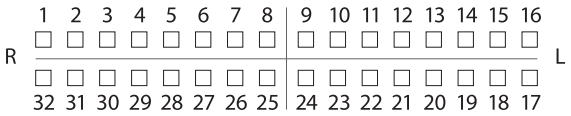
Do not move these teeth (bridges, ankylosed teeth, etc.)



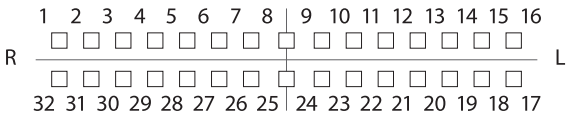
Avoid engagers on these teeth (facial restorations, etc.)



I will extract these teeth before treatment



Leave these spaces open



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