Straight28™ Clear Aligner Prescription

STRAIGHT28

BASIC INFORMATION

Date _____

Doctor's name _____

Patient's name _____

Patient's gender ○ Male ○ Female **Patient's date of birth** ____/____/____

Requested Return Date _____ (Please 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

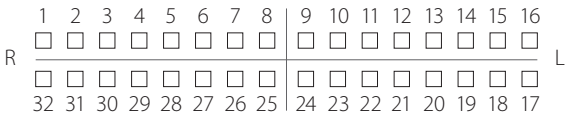
Default options are highlighted in green

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

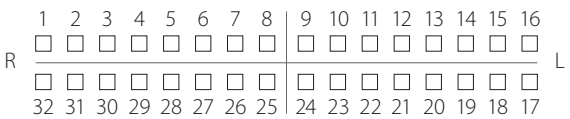
IPR	○ yes	○ no	○ only if needed
Buttons	○ yes	○ no	○ only if needed
Procline	○ yes	○ no	○ only if needed
Expand	○ yes	○ no	○ only if needed
Distalize	○ yes	○ no	○ only if needed

Other instructions:

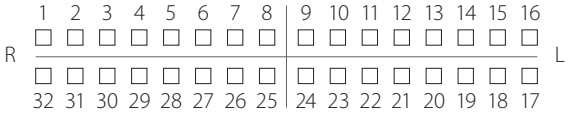
Do not move these teeth (bridges, ankylosed teeth, etc.)



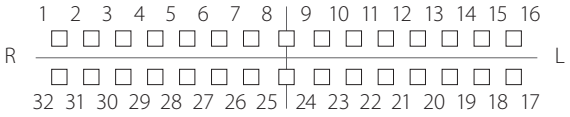
Avoid buttons on these teeth (facial restorations, etc.)



I will extract these teeth before treatment



Leave these spaces open



Please submit this form with your case or email it to contact@SmartDesignsDental.com