

RX for TrueAlign Clear Aligners

Submit this Rx with your scan/model via the Oral Arts customer portal, or email removablescadcam@oralartsdental.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 (molar movements are not allowed)

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 Later

Distal to Canines

POSTERIOR CROSSBITE

Maintain

Correct Premolars

Correct Molars

ADDITIONAL COMMENTS

If you have an offer code, include it here