Orthotech

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Doctor/Practice: ______________________________ Patient: ______________________________

Address: ______________________________ Date Sent: ______________________________

______________________________ Due Date: ______________________________

ClearControl Aligners Rx

Treatment Plan:

Please specify which arch/s that you want aligners fabricated for:

Upper Lower Both

Threshold of Movement per Aligner: 0.20mm OR Custom Threshold: _______ mm

Movement Restrictions:

Do not move indicated teeth
No Restrictions

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Auxiliary Preferences:

Place Attachments on indicated teeth
Do not place attachments on indicated teeth
No Attachments

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Reset Preferences:

Reset to ideal
Reset where indicated
Over correct where indicated

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

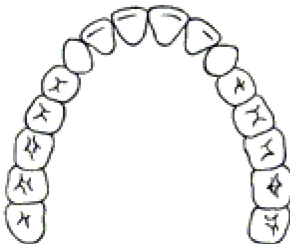
IPR Preferences:

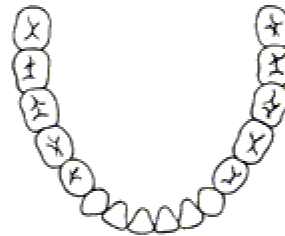
IPR as indicated
No IPR

	4	3	2	1	1	2	3	4	
R	4	3	2	1	1	2	3	4	L

Special Instructions:

Use as needed:





Doctors Signature: Date: ______________

Doctors License No. ______________________________

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