JS Clear Aligner Order Form

1. Clinic / Doctor Information

Clinic Name: _____

Dentist Name: _____

Contact Number: _____

Email: _____

2. Patient Information

Patient Name: _____

Patient ID / Chart No.: _____

Date of Birth: _____

Gender: ☐Male ☐Female

3. Classification

☐ N/A ☐ Class I ☐ Class II div1 ☐ Class II div2
☐ Class III

☐ N/A ☐ Overbite ☐ Anterior Occlusion ☐ Posterior Occlusion

☐ Crowding ☐ Diastemata ☐ Asymmetric ☐ Vertical open bite

☐ Improve smile line ☐ Narrow arch ☐ Prolapse of anterior teeth

☐ Inclined occlusal plane ☐ Abnormal tooth shape

☐ Horizontal open bite (Overjet)

Note

4. Treatment Information

Treated Arch: ☐Upper ☐Lower

Number of Aligners Required: _____

5. Attachments / Implant Instructions

Attachments (location/quantity): _____

Movement Restrictions (teeth not to be moved): _____

6. IPR / Other Instructions

Interproximal Reduction (IPR): ☐Required ☐Not Required

Special Instructions: _____

7. Scan / 3D Data Submission

Scan Data Submission: ☐Intra-oral Scan ☐Model/Impression

CBCT Included: ☐Yes ☐No

8. Delivery & Schedule

Order Date: ___ (YYYY-MM-DD)

Desired Delivery Date: ___ (YYYY-MM-DD)

Delivery Method: ☐Clinic Pickup ☐Courier

Delivery Address: _____

9. Signature & Approval

Doctor's Signature: _____

Approval Date: ___ (YYYY-MM-DD)