RX FOR CLEAR ALIGNER DESIGN

gcdl
complete dental solutions
GCDL Aligners powered by ARGEN

Doctor:_____

Doctor Email:_____
(for design approval)

Patient:_____

TREATMENT SPECIFICATIONS

TREATMENT ☐ Upper Esthetic Treatment
☐ Lower Esthetic Treatment

ALLOW INCISOR ☐ Yes, tooth #_____

EXTRACTIONS ◯ Yes, tooth #_____
◯ No

ANKYLOSIS/ IMPLANT ◯ Yes, tooth #_____
◯ No

MIDLINE *(mark only if needed)*

Maintain: ◯ Yes
◯ No

Move: ☐ Upper ☐ Left ☐ Right
☐ Lower ☐ Left ☐ Right

ANTERIOR POSTERIOR RELATION

Maintain: ◯ Yes
◯ No Move: ◯ Right ◯ Left

Improve Canine Relationship Only: ☐ Right ☐ Left

CROWDING

Upper	As Needed	Primarily	No	Lower	As Needed	Primarily	No
Expansion	◯	◯	◯	Expansion	◯	◯	◯
IPR	◯	◯	◯	IPR	◯	◯	◯

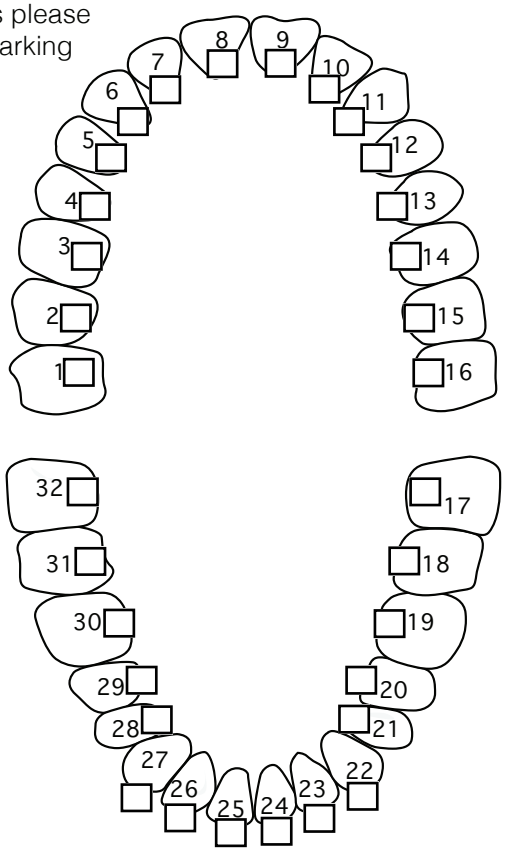
OVERJET & OVERBITE

	Overjet	Overbite
Maintain	◯	◯
Improve	◯	◯

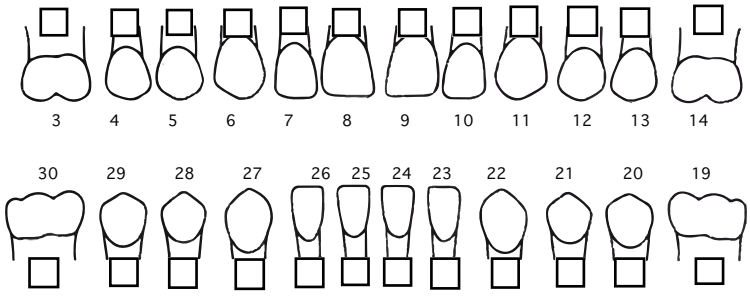
TOOTH SIZE DISCREPANCY

IPT in Opposite Arch ☐
Leave Spaces Open ☐ Distal to Laterals
☐ Distal to Canines

If Patient has any fixed bridges please specify by marking in red



Mark Where Attachments are Excluded:



COMMENTS, FURTHER SPECIFICATIONS:

Clear Form

Submit Form