

G-Force Clear Aligner Rx

Doctor: _____

Patient: _____

TREATMENT SPECIFICATIONS

TREATMENT ☐ Upper Esthetic Treatment Lower
☐ Esthetic Treatment

ALLOW IPR ☐ Yes
☐ No

ALLOW INCISOR EXTRACTIONS ☐ Yes, tooth # _____
☐ No

ANKYLOSIS /IMPLANT (TOOTH NOT MOVED) ☐ Yes, tooth # _____
☐ No

MIDLINE

Maintain: ☐ Upper ☐ Lower **Move:** ☐ Upper ☐ Lower ☐ Left ☐ Right ☐ Left ☐ Right

ANTERIOR POSTERIOR RELATION

Maintain ☐ Right ☐ Left

Improve Canine Relationship Only: ☐ Right ☐ Left

CROWDING

		As Needed	Primarily			As Needed	Primarily
Upper	Expansion	☐	☐	Lower	Expansion	☐	☐
	IPR	☐	☐		IPR	☐	☐

OVERJET & OVERBITE

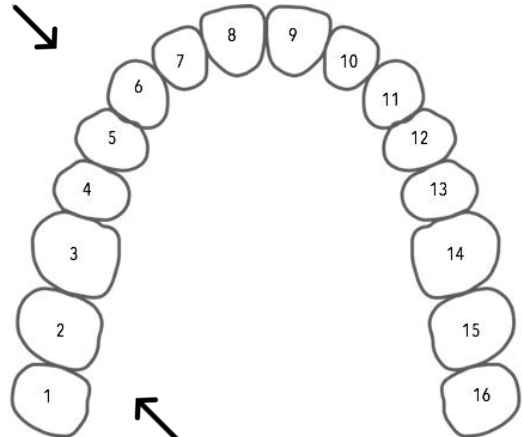
	Overjet	Overbite
Maintain	☐	☐
Improve	☐	☐

TOOTH SIZE DISCREPANCY

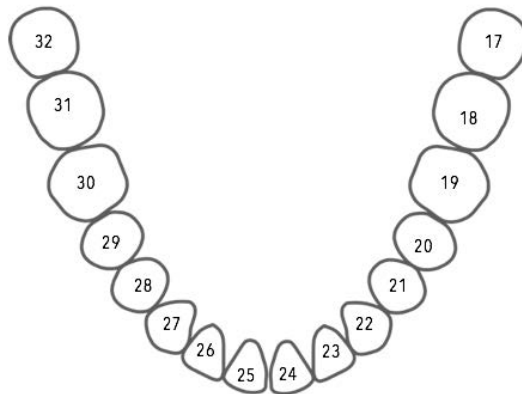
IPR in Opposite Arch ☐

Leave Spaces Open: ☐ Distal to Laterals
☐ Distal to Canines

✓ Indicate where attachments are not allowed



✓ Specify teeth excluding IPR



COMMENTS, FURTHER SPECIFICATIONS: