YOUR SMILE™ FACTOR
CLEAR ALIGNER SYSTEM

ORTHO DESIGN Form

Doctor Information:

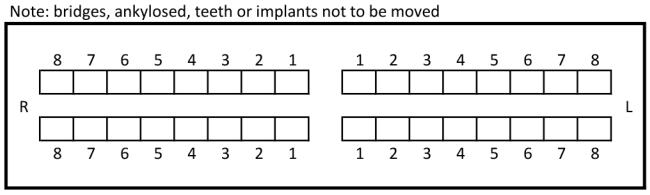
Doctor Name:
Practice Name:
Phone / Email:

Patient Information:

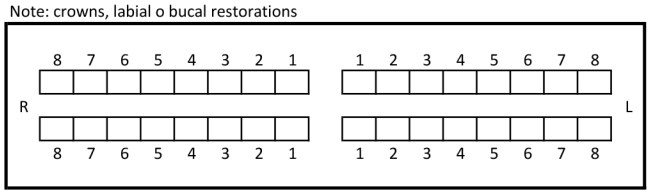
Name:
DOB:
Gender:

Treat Arches: (circle one) Upper Only Lower Only Both

Do not move these teeth:
Note: bridges, ankylosed, teeth or implants not to be moved



Do not place attachments on these teeth:
Note: crowns, labial o bucal restorations



Midline Change:

Recommended Limit <2mm

☐	Maintain Upper /	MOVE	☐ Right	☐ Left
☐	Maintain Lower /	MOVE	☐ Right	☐ Left

Crownding Resolution:

Upper							
Procline	☐	Primarily	☐	As needed	☐	None	
Expand	☐	Primarily	☐	As needed	☐	None	
Anterior IPR	☐	Primarily	☐	As needed	☐	None	
Posterior IPR Right	☐	Primarily	☐	As needed	☐	None	
Posterior IPR Left	☐	Primarily	☐	As needed	☐	None	
Lower							
Procline	☐	Primarily	☐	As needed	☐	None	
Expand	☐	Primarily	☐	As needed	☐	None	
Anterior IPR	☐	Primarily	☐	As needed	☐	None	
Posterior IPR Right	☐	Primarily	☐	As needed	☐	None	
Posterior IPR Left	☐	Primarily	☐	As needed	☐	None	

Spacing Resolution:

Upper

☐ Close all the spaces ☐ Leave spaces, specify where

Lower

☐ Close all the spaces ☐ Leave spaces, specify where

Anterior - Posterior (A-P) Relationship:

		☐ Right	☐ Left
☐	Maintain	☐	☐
☐	Improve canine relationship up to 2mm per quadrant	☐	☐
☐	Correction to Class 1 (canine & molar)	☐	☐
☐	Distalization up to 2 mm per quadrant	☐	☐