

## Rx Pre-Submission Form

### General Information

Doctor's Name: \_\_\_\_\_ Doctor's Email: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ Gender:  M  F Date of Birth: \_\_\_\_\_

### Present Clinical Condition

Patient's Chief Complaint: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Canine Class Relationship Right \_\_\_\_\_ Left \_\_\_\_\_  
 Molar Class Relationship Right \_\_\_\_\_ Left \_\_\_\_\_  
 Upper Midline:  Centered  Shifted Right \_\_\_\_\_ mm  Shifted Left \_\_\_\_\_ mm  
 Lower Midline:  Centered  Shifted Right \_\_\_\_\_ mm  Shifted Left \_\_\_\_\_ mm

### Instructions (Default options are highlighted in pink)

Treat Arches:  Upper  Lower  
 Include Final Retainer:  Upper  Lower  
 Include Retainer (3-Pack) & Extended Care Package

	Maintain	Improve	Idealize
<input type="checkbox"/> Upper Midline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Midline	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overjet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Overbite	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Canine Relationship	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Molar Relationship	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Posterior Crossbite	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	If Needed
<input type="checkbox"/> IPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Engagers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Procline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Expand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Distalize	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Special Instructions:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

Date: \_\_\_\_\_ License No.: \_\_\_\_\_

### Enclosed Records (Please email photos to photos@smileshapers.com with patient and Doctor names)

Digital Scans  PVS Impressions  Bite Registration

### X-rays:

Pano  FMS

### Photos:

Face Frontal Smiling  
 Right Side in Occlusion (close-up)  
 Left Side in Occlusion (close-up)  
 Frontal in Occlusion (close-up)

### Do not move these teeth:

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

### Avoid engagers on these teeth:

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

### I will extract these teeth before treatment:

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

### Leave these spaces open:

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