Southern Cross Dental | invisalign

SEND IMAGES via MySCD | **TRACK YOUR CASE** scdlab.co.nz

ADDITIONAL ALIGNERS

(EXPRESS, LITE, MODERATE & COMPREHENSIVE)

Account Number ☐☐☐☐☐

Dentist ____________________ Invoice Name ____________________

Invoice Address ____________________ Suburb ____________ Postcode ____________

Tel ____________________ Email ____________________

Patient ID ____________________ Date ____________________

Patient ID - If patient name is listed here, please ensure you have written patient consent.

Patient D.O.B ____________________

INSTRUCTIONS

1. Hold patient at current/best-fitting aligner.
2. Prior to taking new impression, remove existing attachments and buttons as new/different attachments and buttons may be required.
3. Please provide a set of 8 new clinical photos, PVS impressions of both arches and bite registration.

1. REASON FOR SUBMISSION

- ◯ Teeth are not tracking
- ◯ Treatment plan change
- ◯ Patient has new restoration or dental work
- ◯ Patient was not compliant
- ◯ Needs finishing improvements
- ◯ Other (please specify) ____________________

2. WHAT ALIGNER IS PATIENT CURRENTLY WEARING?

- ◯ Upper aligner number: ____________
- ◯ Lower aligner number: ____________

3. ARCH TO TREAT

◯ Both ◯ Upper ◯ Lower

4. ARE YOU SENDING NEW IMPRESSION/SCAN?

(If requesting treatment on both arches, it is recommended that impressions/scan are sent for both arches)

Upper arch ◯ Yes ◯ No

Lower arch ◯ Yes ◯ No

5. HOW WOULD YOU LIKE YOUR TREATMENT PLAN SET UP?

- ◯ Same final tooth position as the original ClinCheck® treatment plan
- ◯ Finishing for the current tooth position
- ◯ Other (Specify in Treatment Instructions)

6. TOOTH MOVEMENT RESTRICTIONS

(EX. BRIDGES, ANKYLOSED TEETH, IMPLANTS, ETC.)

- ◯ None (move all teeth)
- ◯ These specific teeth should not be moved

	1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	
R	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	L
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	

Doctor is solely responsible for the completion and interpretation of radiographs and other diagnostic records.

7. ATTACHMENTS (TO SPECIFY ATTACHMENTS, SEE CLINICAL PREFERENCES)

- ◯ Place attachments as needed (to specify attachment defaults for certain movements, see Clinical Preferences)
- ◯ Do not place attachments on these teeth

	1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	
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Please contact SCD Invisalign Department for the latest fee charges on **09 379 9778** or email: **invisalign@scdlab.com**

8. IPR

- ◯ Perform IPR as needed
- ◯ Do not perform any IPR
- ◯ Do not perform IPR on these specific contacts

	1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	
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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	

9. PRECISION CUTS

- ◯ None
- ◯ Same placements as previous treatment plan
- ◯ Place Precision Cuts as per my Clinical Preferences
- ◯ Place Precision Cuts as specified in Precision Cuts Interface

10. RESIDUAL SPACES

- ◯ None
- ◯ Close the following residual spaces (also, specify the amount of residual space present)

TREATMENT INSTRUCTIONS

Upper arch

Lower arch

CASE CHECK LIST

- ◯ 8 Clinical Photos
- ◯ Upper PVS Impression
- ◯ Lower PVS Impression

Impressions must be taken on Invisalign trays.

Please ensure all of the above are submitted to SCD Invisalign to process your case.

Postal Address Level 1, 6 Auburn Street, Grafton, Auckland 1023

T. 09 379 9778 | **F.** 09 379 9777

By submitting this form, you agree to the terms and conditions, which can be found on our website scdlab.co.nz

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