Southern Cross Dental | invisalign®

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# PRESCRIPTION & DIAGNOSIS

Dentist _____ Invoice Name _____

Invoice Address _____ Suburb _____ Postcode _____

Tel _____ Email _____

Account Number ☐☐☐☐☐

Patient ID _____ Date _____

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

Patient D.O.B _____

## 1. INVISALIGN TREATMENT

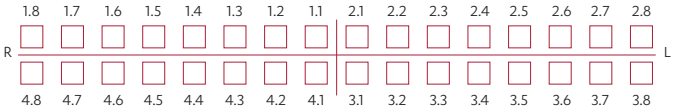
- ◯ Express (7-stage)
- ◯ Moderate (26-stage)
- ◯ Lite (14-stage)
- ◯ Comprehensive (3 Additional Aligners, 3 Years)
- ◯ Comprehensive (Unlimited, 5 Years)

## 2. TREATED ARCHES

◯ Upper Only ◯ Lower Only ◯ Both

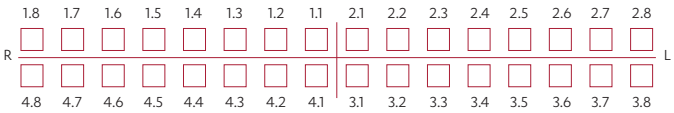
## 3. TOOTH MOVEMENT RESTRICTION

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




## 4. DO NOT PLACE ATTACHMENTS ON THESE TEETH

(Note: crowns, labial or buccal restorations)




## 5. ANTERIOR - POSTERIOR (A-P) RELATIONSHIP

| | Right | Left |
|---|---|---|
| ◯ Maintain | ◯ | ◯ |
| ◯ Improve canine relationship only | ◯ | ◯ |
| ◯ Improve canine & molar relationship up to 4 mm | ◯ | ◯ |
| ◯ Correction to Class I (canine & molar) | ◯ | ◯ |
| ◯ Distalisation (up to 2 mm, without elastics) | ◯ | ◯ |

## 6. OVERJET UPPER

- ◯ Show resulting after alignment
- ◯ Maintain initial (may require IPR)
- ◯ Improve resulting

## 7. OVERBITE

- ◯ Show resulting after alignment
- ◯ Maintain initial (may require IPR)
- ◯ Improve resulting

## 8. BITE RAMPS

- ◯ None
- ◯ Place Bite Ramps on lingual of these upper teeth

**Incisors**

- ◯ Central incisors ◯ Lateral incisors
- ◯ Note: Placement of Bite Ramps will take the place of the upper anterior intrusion features (pressure areas) if applicable.

◯ **Canines**

## 9. MIDLINE CHANGE: RECOMMENDED LIMIT <2MM

| | | | |
|---|---|---|---|
| ◯ Maintain **Upper**/MOVE | ◯ Right | ◯ Left | ◯ 1-2mm |
| ◯ Maintain **Lower**/MOVE | ◯ Right | ◯ Left | ◯ 1-2mm |

**Cancellation fee applies once the case has been submitted to Align Technology.**
Please contact SCD Invisalign Department for the latest fee charges on **09 379 9778** or email: **invisalign@scdlab.com**

## 10. SPACING RESOLUTION

**Upper**

- ◯ Close all spaces
- ◯ Leave space/s, specify where _____

**Lower**

- ◯ Close all spaces
- ◯ Leave space/s, specify where _____

## 11. CROWDING RESOLUTION

**Upper**

| | | | |
|---|---|---|---|
| Procline: | ◯ Primarily | ◯ As needed | ◯ None |
| Expand: | ◯ Primarily | ◯ As needed | ◯ None |
| IPR Anterior: | ◯ Primarily | ◯ As needed | ◯ None |
| IPR Posterior Right: | ◯ Primarily | ◯ As needed | ◯ None |
| IPR Posterior Left: | ◯ Primarily | ◯ As needed | ◯ None |

**Lower**

| | | | |
|---|---|---|---|
| Procline: | ◯ Primarily | ◯ As needed | ◯ None |
| Expand: | ◯ Primarily | ◯ As needed | ◯ None |
| IPR Anterior: | ◯ Primarily | ◯ As needed | ◯ None |
| IPR Posterior Right: | ◯ Primarily | ◯ As needed | ◯ None |
| IPR Posterior Left: | ◯ Primarily | ◯ As needed | ◯ None |

## 12. COMPLIANCE INDICATOR

- ◯ Yes (fee applies)
- ◯ No

Free additional aligners within Treatment Expiration Date (1 for Express Package, 2 for Lite Package and unnlimited for Moderate and Comprehensive Packages).

## ADDITIONAL INSTRUCTIONS

## CASE CHECK LIST

- ◯ OPG
- ◯ Lateral Ceph
- ◯ 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