Contact us:
Tel(in): +91 9072 334033, +91 9072 335033
E-mail: info@clearbeealigner.com

CLEARBEE PRESCRIPTION FORM

Doctor's information

Doctor's Name : Dr.....
Nationality : .....
Clinic Name : .....
Clinic Address : .....
.....
City/Town:.....State:.....PIN:.....
Tel : Country code: ..... Ph no. .....
Email Address: .....

Patient information

Patient name: .....
Age: ..... Sex: .....
Nationality: .....
Address: .....
.....
City/Town:.....State:.....PIN:.....
Tel : Country code: ..... Ph no. .....
Email Address: .....

Chief complaint: .....
.....
Clinical findings and diagnosis: .....
.....
.....

Midline deviation :
Upper (mm) .....
Lower (mm) .....

Molar relation: (Class)
Right: .....
Left : .....

Canine relation: (Class)
Right: .....
Left : .....

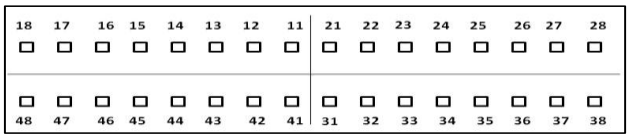
Clinical notes : .....
.....
.....

TREATMENT PLANNING

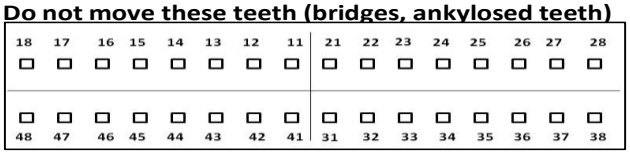
	Retain	Improve	Rectify
MIDLINE: Upper:	☐	☐	☐
Lower:	☐	☐	☐
OVERJET:	☐	☐	☐
OVERBITE:	☐	☐	☐
CROSSBITES:	☐	☐	☐

	Yes	No
PROCLINE:	☐	☐
EXPAND:	☐	☐
IPR:	☐	☐
DISTALISE:	☐	☐

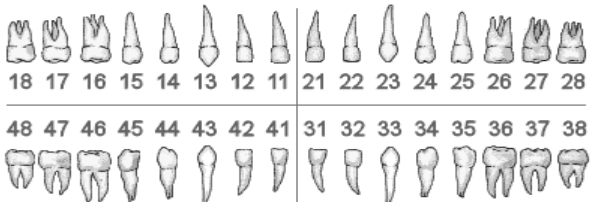
Extract these teeth.



Do not move these teeth (bridges, ankylosed teeth)



IPR



OTHER INSTRUCTIONS:.....
.....

TREATMENT GOALS : .....
.....

I have carefully read, understood and accept the Terms and Conditions of Clearbee Aligners.
Doctor's name :
Signature: Date: