



## Smile Shapers RX 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)

New Order/Case  Refinement Case  
If Refinement, original case # \_\_\_\_\_  
Original length of treatment \_\_\_\_\_ steps  
Treat Arches:  Upper  Lower

	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"/>

### Retainers (Smile Shapers recommends waiting for the treatment plan to be completed to fabricate the final retainers)

Include Final Retainer:  Upper  Lower  
 Include 3 Pack Retainer & Extended Care Package

### 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"/>
	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"/>
	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"/>
	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

### Special Instructions:

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

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_ License No.: \_\_\_\_\_