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 gray)

Treat Arches: ☐ Upper ☐ Lower

Retainers (Should proposed treatment plan contain attachments Phase Ortho recommends waiting to order retainers once the treatment plan has been completed.)

Include Final Retainer: ☐ Upper ☐ Lower

☐ Include Retainer (3-Pack) & Extended Care Package

	Maintain	Improve	Idealize
☐ Upper Midline	☐	☐	☐
☐ Lower Midline	☐	☐	☐
☐ Overjet	☐	☐	☐
☐ Overbite	☐	☐	☐
☐ Canine Relationship	☐	☐	☐
☐ Molar Relationship	☐	☐	☐
☐ Posterior Crossbite	☐	☐	☐

	Yes	No	If Needed
☐ IPR	☐	☐	☐
☐ Engagers	☐	☐	☐
☐ Procline	☐	☐	☐
☐ Expand	☐	☐	☐
☐ Distalize	☐	☐	☐

Enclosed Records

☐ 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	L
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Special Instructions:

_____

_____

_____

_____

_____

I will extract these teeth before treatment:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	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

Dr. Signature: _____

Date: _____ **License No.:** _____