

## 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
<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"/>

**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	<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"/>	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	<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"/>	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

**Special Instructions:**

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

**Dr. Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **License No.:** \_\_\_\_\_

**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"/>	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