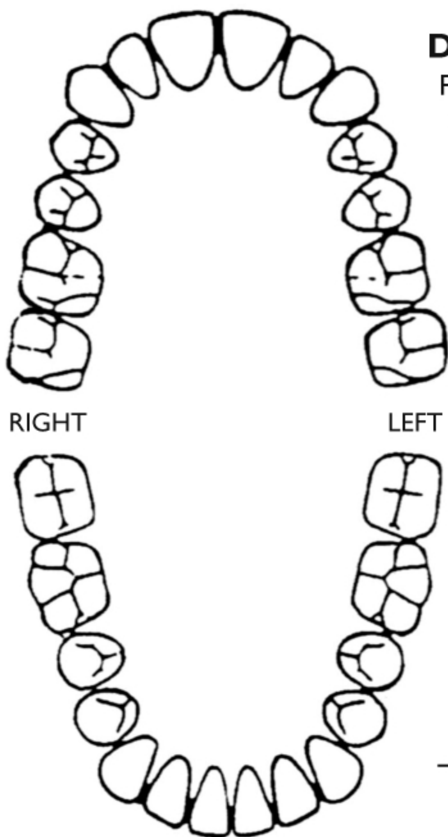
ClearAligner™



DOCTOR'S PRESCRIPTION

Please send a high quality model poured in dental stone with both buccal and lingual sides of the teeth fully visible. Mark on the diagram the teeth to be moved. Reproximation of the teeth is left to the doctor's discretion.

Special Instructions:

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Doctor's Name:______________________ Doctor's Account #:____________

Doctor's Address:______________________________

City:______________ State/Prov.:__________ Zip/Postal Code:__________

Doctor's Phone Number:______________________________

Patients Name:______________________ Patient's Age:__________

Doctor's Signature:______________________ Date:__________

Doctor's License Number:______________________________

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Doctor retains white copy. Send yellow and pink copies to Clear**Aligner**