PerfectSmile
aligners by SHAW

Case Submission Form

General information

Treatment plan requested for (date) ___ /___ /____
month day year

Doctor: _____

Email address: _____

Practice name: _____

Address: _____ Phone: _____

_____ Cell: _____

Patient's name: _____

Gender: _____ DOB: ___ /___ /____
month day year

Present clinical condition: _____

Patient's chief complaint: _____

_____

Enclosed records:

Digital scans ☐ PVS impressions ☐ 100 hour alginate ☐

Bite registration ☐

X rays: Lateral ceph ☐ (required for cephalometric tracing)

Panoramic ☐ or FMS ☐

Photos: Face frontal ☐ Face profile ☐ Face frontal smiling ☐

Intraoral photos ☐

PerfectSmile will provide a complementary cephalometric tracing helping to achieve a more accurate diagnosis. It will be delivered with the virtual treatment preview.

info@perfectsmilebyshaw.com
www.perfectsmilebyshaw.com
/ @perfectsmilebyshaw

Please Treat: Upper arch ☐ Lower arch ☐ Both arches ☐

Main treatment objectives		**maintain**	**improve**	**fully correct**
○ Overjet		☐	☐	☐
○ Overbite		☐	☐	☐
○ 3 to 3 alignment		☐	☐	☐
○ Bicuspids alignment		☐	☐	☐
○ Upper midline		☐	☐	☐
○ Lower midline		☐	☐	☐
○ Canine relationship	**Right**	☐	☐	☐
	Left	☐	☐	☐

		maintain	**expand**	**constrict**
○ Arch width	**Upper**	☐	☐	☐
	Lower	☐	☐	☐

○ Procline as needed	**Yes** ☐	**No** ☐
○ IPR as needed	**Yes** ☐	**No** ☐

Other instructions:	**For these teeth:**
Do not plan IPR	7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7
Do not plan composite engagers	7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7
I plan to extract	7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7
Do not move	7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7

Space closure indications: _____

Tooth size discrepancy:
Leave space distal to lateral: ☐
Leave space distal to canine: ☐

Special instructions: _____

_____

_____

Dr.'s signature: _____