

Dentist _____ Invoice Name _____
 Invoice Address _____ Suburb _____ Postcode _____
 Tel _____ Email _____
 Account Number Patient ID _____ Date _____
 Patient ID - Please do not use patient's name unless consent is provided, and appropriate form/s have been completed. Patient D.O.B _____

1. INVISALIGN TREATMENT

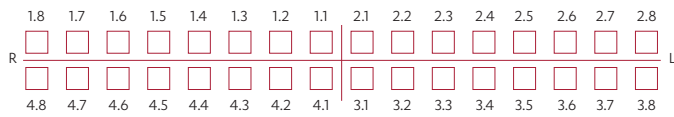
- Express (7-stage)
- Moderate (26-stage)
- Lite (14-stage)
- Comprehensive Option 1 (Unlimited AA, 5 Years)
- Comprehensive Option 2 (3 AA, 3 Years)
- Comprehensive Option 3 (Pay as you go, 4 Years)

2. TREATED ARCHES

- Upper Only
- Lower Only
- Both

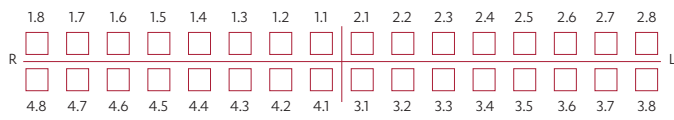
3. TOOTH MOVEMENT RESTRICTION

Do not move these teeth:
 (Note: bridges, ankylosed teeth or implants not to be moved)



4. DO NOT PLACE ATTACHMENTS ON THESE TEETH

(Note: crowns, labial or buccal restorations)



5. ANTERIOR - POSTERIOR (A-P) RELATIONSHIP

- | | | |
|--|-----------------------------|----------------------------|
| <input type="radio"/> Maintain | Right <input type="radio"/> | Left <input type="radio"/> |
| <input type="radio"/> Improve canine relationship only | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Improve canine & molar relationship up to 4 mm | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Correction to Class I (canine & molar) | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> Distalisation (up to 2 mm, without elastics) | <input type="radio"/> | <input type="radio"/> |

6. OVERJET UPPER

- Show resulting after alignment
- Maintain initial (may require IPR)
- Improve resulting

7. OVERBITE

- Show resulting after alignment
- Maintain initial (may require IPR)
- Improve resulting

8. BITE RAMPS

- None
 - Place Bite Ramps on lingual of these upper teeth
- Incisors**
- Central incisors
 - Lateral incisors
 - Note: Placement of Bite Ramps will take the place of the upper anterior intrusion features (pressure areas) if applicable.
- Canines

9. MIDLINE CHANGE: RECOMMENDED LIMIT <2MM

- Maintain Upper/MOVE
- Maintain Lower/MOVE
- Right
- Left
- 1-2mm
- 1-2mm

Cancellation fee applies once the case has been submitted to Align Technology.
 Please contact SCD Invisalign Department for the latest fee charges on 02 8062 9810 or email: invisalign@scdlab.com

10. SPACING RESOLUTION

- Upper**
- Close all spaces
 - Leave space/s, specify where _____
- Lower**
- Close all spaces
 - Leave space/s, specify where _____

11. CROWDING RESOLUTION

- Upper**
- Procline: Primarily As needed None
- Expand: Primarily As needed None
- IPR Anterior: Primarily As needed None
- IPR Posterior Right: Primarily As needed None
- IPR Posterior Left: Primarily As needed None
- Lower**
- Procline: Primarily As needed None
- Expand: Primarily As needed None
- IPR Anterior: Primarily As needed None
- IPR Posterior Right: Primarily As needed None
- IPR Posterior Left: Primarily As needed None

12. COMPLIANCE INDICATOR

- Yes (fee applies)
- No

ADDITIONAL INSTRUCTIONS

CASE CHECK LIST

- Upper intra oral scan
- Lower intra oral scan
- Upper PVS Impression
- Lower PVS Impression
- OPG
- Lateral Ceph
- 8 Clinical Photos

COMPATIBLE SCANNER BRANDS

- Compatible brands excepted with Invisalign
- iTero
 - 3M True Definition
 - Dentsply Sirona CEREC Omnicam
 - 3Shape Trios 3

(Contact SCD Invisalign Team for further information)

Please ensure all of the above are submitted to SCD Invisalign to process your case.