LABORATORY FORM

Doctor's Name _____

Practice Name: _____

Address: _____

Post Code: _____

Telephone: _____

Email: _____

Patient's Name _____

Date of Birth: _____

Gender: M ☐ F ☐

Required by: (Please allow 10 days minimum)

_____

Treatment Requirements: _____

CustomClear Aligner ☐

CustomClear Digitally Debonded Finisher ☐

CASE SUBMISSION

Treat arches
- Upper ☐
- Lower ☐
- Both ☐

Impressions (Both Arches) ☐

Scans ☐

Photographs ☐

Bite Records ☐

TEETH TO BE ALIGNED

DIGITAL TREATMENT PLAN (APS)

(Mid Alignment Cases of less than 6 aligners do not require an APS)

YES I do require a digital treatment plan ☐

NO I do not require a digital treatment plan ☐

*If we do not create a treatment plan for cases of 7 aligners or more, then there is a possibility refinement will be needed. This will be chargeable at a reduced fee

Please contact us for more help:
info@orthocare.co.uk . Telephone 01274 533233
Ortho-Care (UK) Ltd, 1 Riverside Estate, Saltaire, West Yorkshire, BD17 7DR
Please refer to our terms and conditions