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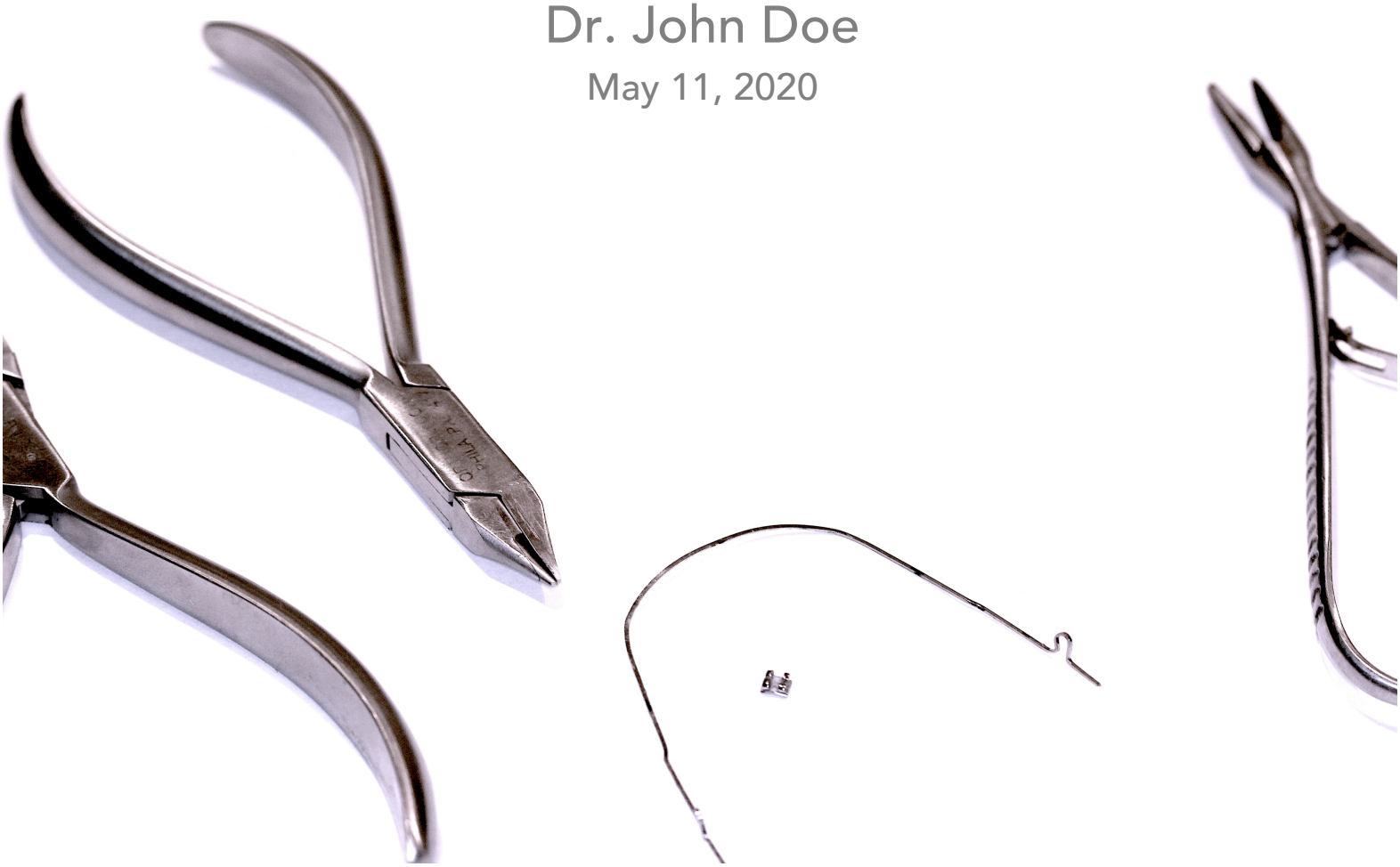
ALIGNER PRESCRIPTION REPORT

Dr. John Doe

May 11, 2020



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ORTHODONTIC ALIGNER PRESCRIPTION REPORT

Dr. John Doe – Patient: Robert Smith

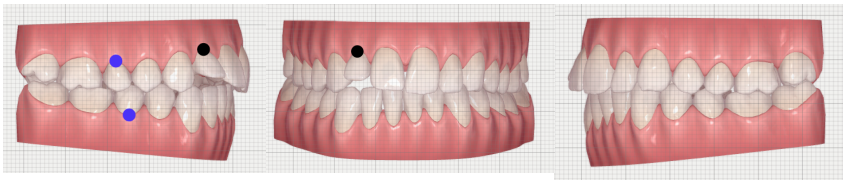
Dear Dr. Doe:

Thank you for consulting with OrthoDesigners regarding your patients' orthodontic needs. We wish you the very best in providing quality orthodontic care to your patient population. Please do not hesitate to contact us for any further assistance.

Please see below a summary of the aligner prescription on May 11, 2020 regarding your patient **Robert Smith**. It was our pleasure providing you with our expert consultation services.

List of Orthodontic Problems

- Severely proclined (flared) #7
- Anterior open bite #7, #8, #9
- Excess overjet
- Non-coincident dental midlines
- Maxillary incisal cant
- End-to-End Class II Canine

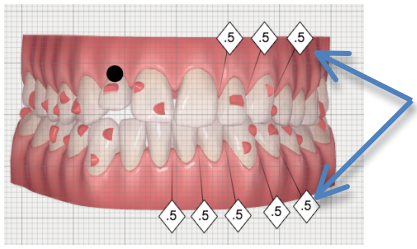


ClinCheck Instructions (detailed explanations in next pages)

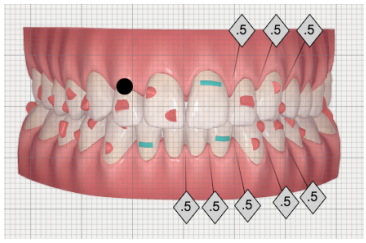
1. Shift Upper Midline 1mm to the Left and Lower Midline 2mm to the Left with IPR
2. Extrude #7 so that it is level with #10 by protruding tooth labially first followed by simultaneous retraction and relative extrusion.
3. Place 3mm horizontal beveled rectangular attachment with bevel facing gingivally for both #7 and #10 to aid with extrusion.
4. Extrude the upper incisors to achieve 3.5mm of OB with anterior contact on all four incisors.
5. Perform all IPR in stage 20.

1. Shift Upper Midline 1mm to the Left and Lower Midline 2mm to the Left with IPR

IPR is a powerful tool to correct non-coincident dental midlines. It is important to determine which midline (upper or lower) is off. In this case, the upper midline is 1mm to the right of the face while the lower midline is 1mm to the right of the upper midline. Therefore, the upper midline needs to be shifted 1mm to the left and the lower midline needs to be shifted 2mm to the leftt to be in line with the new upper midline. It's important to be specific in your Aligner Rx by stating how many millimeters and in what direction you want to shift your midlines. Note how all the IPR is directed on the left sides of both upper and lower arches. Merely stating "perform IPR" may not achieve the desired results of midline correction. For example, if you only state "make the midlines coincident with IPR", the midlines may end up being coincident to each other. However, they may be both off from the facial midline.

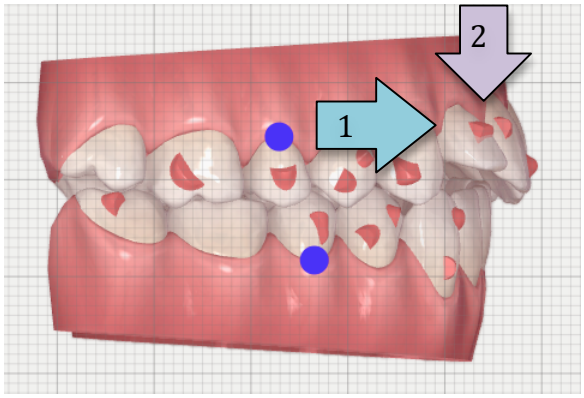


Note how all IPR is directed to the left to shift the upper and lower midlines to be coincident to both the face and to each other



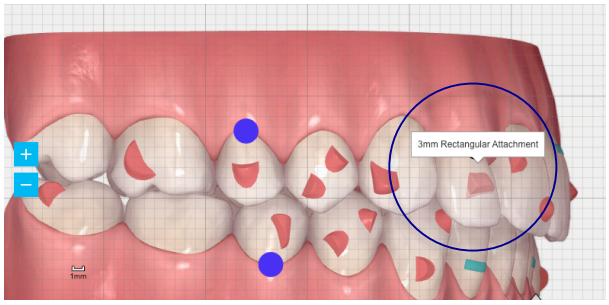
2. Extrude #7 so that it is level with #10 by protruding tooth labially first followed by simultaneous retraction and relative extrusion.

Aligners are better in "push" movements rather than "pull" movements unlike brackets and wires. In order to properly push teeth to move them, a greater amount of surface area is needed. Therefore, extruding anterior teeth, especially laterals with smaller surface areas, is a more difficult movement in aligners. In order to predictably achieve the extrusion with #7, the movements need to be broken down into two stages. Stage 1 (#1 arrow) involves **pushing** tooth #7 out labially so that more of the tooth surface is exposed to the plastic of the aligner. Stage 2 involves **pushing** the tooth downwards (#2 arrow) to extrude it. The type of attachment placed is also important and will be discussed in the next page.



3. Place 3mm horizontal beveled rectangular attachment with bevel facing gingivally for both #7 and #10 to aid with extrusion.

In order to achieve predictable extrusion of tooth #7, a great amount of surface area needs to be exposed to the plastic of the aligner in order to push the tooth to extrude it. Unfortunately, upper laterals are notorious for not tracking well during aligner therapy because they lack a good amount of surface area. Placing a *horizontal rectangular attachment* with a **bevel** will increase the surface area at the gingival portion of tooth #7 therefore increasing surface area to push on to extrude the tooth.



4. Extrude the upper incisors to achieve 3.5mm of OB with anterior contact on all four incisors.

In aligner therapy, it is important to overcorrect your overbite. That means that for anterior open bites, you should end with greater overbite than what you think is ideal and for deep bites, you should end with less overbite (or even an open bite) in your aligner prescription. The reason for this is that the movements you place in you Rx are never fully translated or expressed on the teeth (only about 50-80% of your movement is actually expressed in real life). Therefore, for this anterior open bite case where the four incisors aren't touching, it's important to end with more overbite (3.5mm instead of the ideal 2mm).

5. Perform all IPR in stage 20.

In order to achieve efficiency in your practice, schedule your IPR on the dates you anticipate to see your patient. You should schedule all IPR at the same time whenever feasible so that you don't have to bring the patient in to see you multiple times.