



Order # _____ For Align use only.

Treatment Planning Form - Page 1

INSTRUCTIONS: To provide the best possible treatment for your patient, we ask that you complete this three page Treatment Planning Form. This form will help determine if your patient is an appropriate candidate for the Invisalign System™ and communicate to us your treatment goals. The completed form is to be included in your patient's submission kit along with patient photos, x-rays, bite registration and an upper and lower PVS impression. For additional forms, go to www.invisalign.com.

GENERAL INFORMATION

DOCTOR

Name: Dr. Thomas S. Davant VI
 Ship To
 Street Address: 101 Summit Parkway
 City, State, ZIP: Columbia, S.C. 29229
 County/Country: Richland / USA
 Telephone: 803-736-7333
 FAX: 803-736-0933
 Contact Person: Kristie Williams
 Best time to call office: 9:00 - 12:30
 E-mail: DRDAVANT@ad.com

Bill To
 Street Address: SAME
 City, State, ZIP: _____
 County/Country: _____
 Telephone: _____
 FAX: _____
 Contact Person: _____
 Best time to call office: _____
 E-mail: _____

PATIENT

Name: _____
 Chief Concern: Spacing
 Gender: Female

Date of Birth: 1/22/85
 Today's Date: 2/8/02
 Age: 17

Please check the one that applies to your case:

- Private Practice Case
- University Research Case University Name _____
- Resident Case University Name _____ Faculty Name _____
 Student Name _____ Yr. of Graduation _____

SELECTION CRITERIA

SECTION I. CASE TYPES

Please check the appropriate boxes that apply to your patient's malocclusion. (U=Upper Arch, L=Lower Arch)

Mild Spacing (1-3 mm)

Space closure, no sagittal, vertical, or transverse changes

U L

Moderate Spacing (4-6 mm)

Space closure, no sagittal change

U L

Mild Crowding (1-3 mm)

Correction of crowding (mild proclination of incisors, interproximal reduction, 2-3 mm of dental expansion per quadrant maximum, and no sagittal change)

U L

Moderate Crowding (4-6 mm)

Correction of crowding (mild proclination of incisors, interproximal reduction, 2-3 mm of dental expansion per quadrant maximum and/or extraction of lower incisor), and up to 2 mm maxillary distalization toward Class I

U L

Please continue to the next page.

Align Technology, Inc. reserves the right to not accept any case.

Doctor Name: Tom DAVITT

Patient Name: _____

Order No. _____

For Align use only.



Treatment Planning Form

CLINICAL INFORMATION

MISSING TEETH:

NONE

R 87654321|12345678 L
87654321|12345678

CR/CO SHIFT:

NO

YES ___ mm DIRECTION _____

MAXILLARY MIDLINE IN RELATION TO FACE:

CENTERED

SHIFTED: ___ mm to L/R → FIX? Y/N

MANDIBULAR MIDLINE IN RELATION TO FACE:

CENTERED

SHIFTED: ___ mm to L/R → FIX? Y/N

ANKYLOSED/IMPACTED TEETH:

NONE

R 87654321|12345678 L
87654321|12345678

FACIAL/BUCCAL RESTORATIONS:

NONE

R 87654321|12345678 L
87654321|12345678

TEETH WITH BRIDGES:

NONE

R 87654321|12345678 L
87654321|12345678

TREATMENT GOALS

TREAT ARCHES:
(circle one)

BOTH

UPPER ONLY

LOWER ONLY

TREATMENT GOALS:
(circle all that apply)

Canine R:

Class I

Class II

Class III

MAINTAIN

Molar R:

Class I

Class II

Class III

MAINTAIN

Canine L:

Class I

Class II

Class III

MAINTAIN

Molar L:

Class I

Class II

Class III

MAINTAIN

CORRECT A-P DISCREPANCY (MAX 2 mm) BY:
(circle all that apply)
(PRN= as needed)

Molar R

Canine R

Canine L

Molar L

MAINTAIN

MAINTAIN

MAINTAIN

MAINTAIN

DISTALIZE U

DISTALIZE U

DISTALIZE U

DISTALIZE U

STRIP 3-6 PRN

STRIP 3-6 PRN

STRIP 3-6 PRN

STRIP 3-6 PRN

CORRECTION OF CROWDING:
(circle all that apply)

PROCLINE INCISORS

U

L

POSTERIOR DENTAL EXPANSION

U

L

DISTALIZE UPPER

UPPER INTERPROXIMAL REDUCTION

LOWER INTERPROXIMAL REDUCTION

EXTRACT LOWER INCISOR → R 2 1 1 2 L

NOT APPLICABLE (circle one)

CORRECTION OF SPACING
(circle one)

RETRACT POSTERIORES FIRST BEFORE ANTERIORES
EN MASSE SPACE CLOSURE

IF TOOTH-SIZE DISCREPANCY:
(circle all that apply)

LEAVE SPACE:

DISTAL TO LATERAL INCISOR

EQUALLY DISTRIBUTED

MESIAL TO LATERAL INCISOR

STRIP LOWER INCISORS/CLOSE ALL SPACES

CURVE OF SPEE:
(circle one)

MAINTAIN

LEVEL AS NEEDED (may require attachments)

SPECIAL INSTRUCTIONS: Phax candidate both arches and close bite

WILL THE PATIENT OBJECT IF ATTACHMENTS ARE REQUIRED?
(Align will place them only as needed. Results may be compromised if not used.)

YES

NO

HAS THE PATIENT'S CASE BEEN SHIPPED TO ALIGN BEFORE?

YES

NO

IF YES, DATE _____

HOW MANY MONTHS WOULD THIS CASE TAKE IN CONVENTIONAL APPLIANCES?
(May not relate to the timing of the case with Invisalign.)

12 months

DOCTOR'S SIGNATURE: [Signature] DATE: 2/7/02

Align Technology, Inc. reserves the right to not accept any case.