

# Star Aligner Prescription

Customized, clear appliances for minor anterior alignment

DR. NAME \_\_\_\_\_ ACCT. # \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

LICENSE # \_\_\_\_\_ FAX # \_\_\_\_\_

(Patient's Last Name)

(Patient's First Name)

DATE SENT --

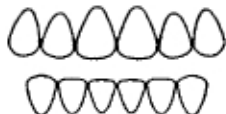
DATE WANTED --

(2 days prior to insertion)

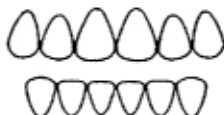
- Upper Star Aligner (3 appl.)
- Lower Star Aligner (3 appl.)
- Less than 3 appliances if possible to obtain desired correction
- I anticipate using more than three appliances for the desired correction
- Close all spaces if possible
- Strip as needed
- Strip where indicated
- Teeth have been stripped in advance

### Reset Shaded Teeth

(Resetting cuspids is not advised without careful evaluation)



### Stripping requested



Special Instructions: \_\_\_\_\_

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|---|---|--|-------------------------------------|--|
| <input type="checkbox"/> Standard Rx    | <input type="checkbox"/> Frankel Rx     | <input type="checkbox"/> Labels          | <input type="checkbox"/> Boxes      | <input type="checkbox"/> Color Chart     |
| <input type="checkbox"/> Study Model Rx | <input type="checkbox"/> Twin Block™ Rx | <input type="checkbox"/> Splint Rx       | <input type="checkbox"/> Pkg Foam   | <input type="checkbox"/> Star Aligner Rx |
| <input type="checkbox"/> C/B Rx         | <input type="checkbox"/> Herbst® Rx     | <input type="checkbox"/> Impression Bags | <input type="checkbox"/> Price List | <input type="checkbox"/>                 |



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