

In-Line Case Evaluation Request Form

Dentist Information:

Dentist name.....
 Practice name.....
 Practice address.....
 Tel.....
 E-mail.....
 Dentist's signature.....

3D Digital Quotation Standard Text Quotation (please tick appropriate box)

Patient Information:

Patient name.....
 D.O.B..... Gender (M/F).....
 Patients Signature.....

Clinical Information:

Upper Right								Upper Left							
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Lower Right								Lower Left							

f = missing tooth k = crowns x = teeth to be extracted d = devitalised teeth b = bridge i = implant

Dentists please check the general health of the patient's teeth and gums, including the health of the tooth enamel where inter-proximal enamel reduction may be required. Please note any perceived problems below.

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Treatment Objectives: (Please tick)

Alignment of the teeth in the upper arch from UR.....to UL.....(in the range UR5 - UL5)

Alignment of the teeth in the lower arch from LR.....to LL.....(in the range LR5 - LL5)

Closure of gaps between the following anterior teeth.....

De-rotation of the following anterior teeth.....

Simple pre-cosmetic alignment upper

Simple pre-cosmetic alignment lower

Extrusion of the following teeth..... (Following completion of normal In-Line treatment)

Intrusion of the following teeth..... (Following completion of normal In-Line treatment)

Other (Please specify).....

Please send this form with accurate silicone impressions and a wax bite to FREEPOST IN LINE.