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CLEAR ALIGNER PRESCRIPTION

• Dental Clinic

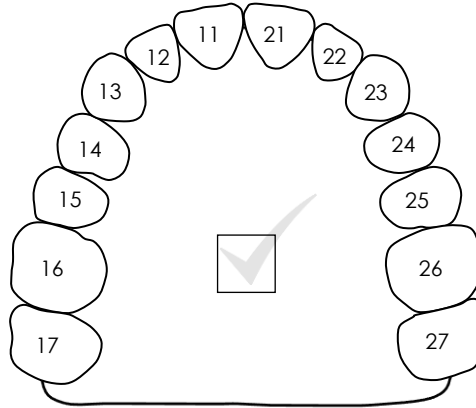
Name _____

Tel _____

Doctor's Name _____

Order Date _____

E-mail Address _____



• Patient

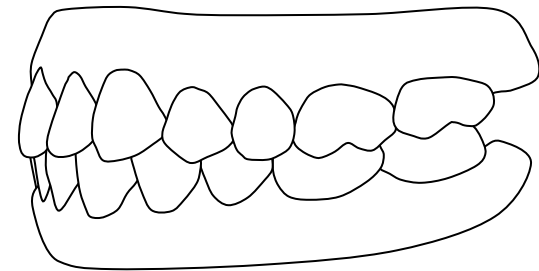
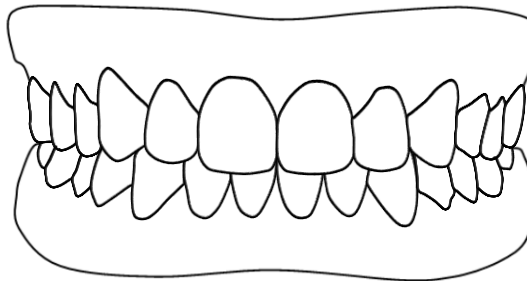
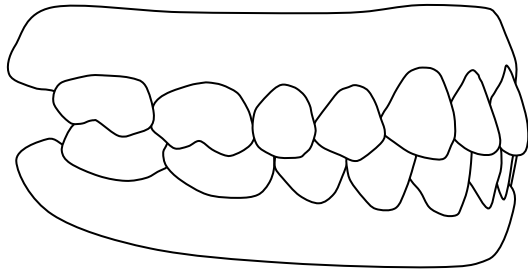
Name _____

Age _____ Male Female

Appointment Date & Time _____

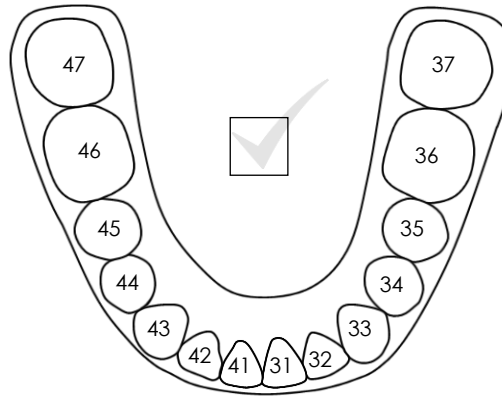
Consultation Call

R



L

• Chief Complaint & Tx Plan



• Directions

