LABORATORY Order form: ClearSmile appliance

Patient name			Express Ar (3 working o	chwize days) Chargeable		Standard Archwize (6 working days)
Clinician			Case Support ID #			
Practice name			Impression Date		Fit Date	
Address Country Postco	ode		Right sid 3 4			Left side 4
Phone Email			5 6 (7 (8 (Upper Jaw		5 6 7 * 8
Reset teeth			8 (Lower Jaw	, ()	¥ 8 7
U 65432112	345	6	6 (5	AN AN	(* D) 6 5
L 654321 12	345	6	4 Right sic	3 2 1		Left side
Appliances		Indicate any landmark teeth on chart above.				
U L Inman Aligner Super Slim Bow	U	L	ClearSmile Aligner	U	L	Refiners
U L Inman Aligner Standard	U	L	ClearSmile Brace	U	LE	ssix Retainer
U L ClearSmile Aligner Light	U	L	ClearSmile Brace Clarity Advanced	U	L Bo	onded Retainer with Jig
Notes Please use this space for appliance descriptions and sur	U ndry item ord	L	ClearSmile Discreet Brace	U	L BI	eaching Trays

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This is a custom made medical device that has been manufactured to satisfy the desion characteristics and properties specified by the prescriber for the above named patient. This medical device is intended for the exclusive use by the patient and conforms to the

relevant essential requirements specified in Annex I of the Medical Devices Directive and the United Kingdom Medical Devices Regulations. (93/42 EEC) MHRA No. CA 014 107