LightForce Treatment Form

1. Patient Information (*all fields marked with * are required*):

*First:	Middle:	*Last:
*DoB:	*Gender:	Practice Patient ID:

2. Records Submitted in LightForce Portal (*provide staff member initials when task is complete*):

FaceMap	Submitted		
Photos	Submitted		
Intraoral Scans	Sent from Scanner (iTero or 3Shape)	Submitted in LF Portal	
Radiographs	Pan - Submitted	Ceph - Submitted	2d CBCT - Submitted

3. *Treatment Approach (*choose any one between comprehensive or limited*):

Comprehensive		○ Upper & Lower Same Day
	Stage	○ Upper Arch
		○ Lower Arch

OR

Limited	Upper Arch Only	○ Diagnostic Setup For Opposing Arch
		○ Don't Treat Opposing Arch
	Lower Arch Only	○ Diagnostic Setup For Opposing Arch
		○ Don't Treat Opposing Arch

LightForce Treatment Form

4. *Bite Turbos (*choose one*):

- ○ As Needed
- ○ Add To Posterior - U6s
- ○ Add To Anterior - U1s
- ○ Add to Anterior - U3s
- ○ Do Not Include

5. Smile Arc - Upper Incisors Vertical Movement (*choose one*):

- ○ Maintain
- ○ Extrude
- ○ Intrude
- ○ Other:

6. Midline Correction (*select the corresponding option of Maintain or Improve upper*):

- ○ Maintain
  - ○ Both
  - ○ Upper (Lower will be aligned to upper)
  - ○ Lower (Upper will be aligned to lower)
- ○ Improve upper (Lower will be aligned to upper)
  - ○ To Patient's right
  - ○ To Patient's left
  - ○ Other

Patient Name

First: _____ Last: _____

LightForce Treatment Form

7. Desired Overbite (*choose one*):

- ○ Maintain
- ○ Ideal (LightPlan ideal overbite is 1-3 mm)
- ○ Other

8. Desired Overjet (*choose one*):

- ○ Maintain
- ○ Ideal (LightPlan overjet is 2 mm)
- ○ Other

9. Sagittal Correction (*choose one*):

- ○ Maintain
- ○ Surgical Plan

- ○ Correct with

☐ Right Elastics	☐ Left Elastics	☐ Other Sagittal Correction Appliances
○ Class II ○ Class III	○ Class II ○ Class III	

Special Instructions

Patient Name

First: _____ Last: _____

LightForce Treatment Form

10. Desired IPR (*please specify if IPR is planned to be performed for this patient*):

- ○ Don't Add Any IPR
- ○ As Needed
  - ☐ Anterior, Maximum IPR per contact _____ mm
  - ☐ Posterior, Maximum IPR per contact _____ mm
- ○ Special Instructions

11. Occlusal Pattern (*please specify type of occlusion contacts in the final LightPlan*):

- ○ Heavier anterior contacts and lighter posterior contacts
- ○ Heavier posterior contacts and lighter anterior contacts
- ○ Even contacts
- ○ Other

12. Additional Instructions:

Patient Name

First: _____ Last: _____