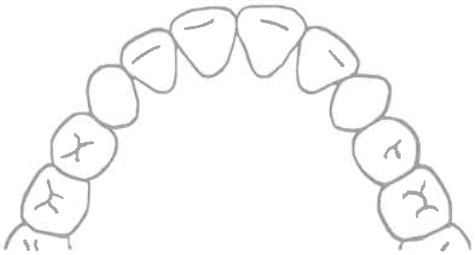
Laboratory Form

Doctor's name:	Patient's name:
Practice name:	DOB:
Practice address:	Gender: Male ☐ Female ☐ Other Please state
Postcode:	Arch treatment: Dual Arch ◯ Single Arch ◯ Retainer ◯ Bonded / Essix U/L ◯
Phone:	Preferred return date:
Emaill:	Other instructions:



ClearAligner

Laindon Barn, Dunton Road, Basildon, Essex, SS15 4DB

01268 417 144
info@clearaligner.co.uk
clearaligner.co.uk

Submission of this form constitues an official order

(CA V2.0 2023)