OHLENDORF
APPLIANCE LABORATORY

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CERTIFIED
DENTAL
LABORATORY

2840 CLARK AVE., P.O. BOX 7212 • ST. LOUIS, MISSOURI 63177

INMAN ALIGNER ORDER FORM

Dr. Name ______________________________ **Patient Name** ______________________

Address ______________________________ **Date Sent** ______________________

City ______________________________ **Date Due** ______________________

State/Zip ______________________________ **Phone #** ______________________

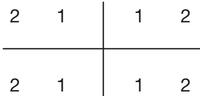
☐ **Upper Inman Aligner** ☐ **Lower Inman Aligner**

☐ **Please call Doctor with design considerations**

Doctor's Phone Number ____

Arch Analysis (Spacewize)	Upper ☐	Lower ☐
Inman Aligner Standard	Upper ☐	Lower ☐
Combined Expansion Screw	Upper ☐	Lower ☐
Posterior Bite Plane	Upper ☐	Lower ☐
Midline Expansion Appliance	Upper ☐	Lower ☐
Fan Screw Appliance	Upper ☐	Lower ☐
Clear Aligners	Upper ☐	Lower ☐
Essix Retainer	Upper ☐	Lower ☐
Wire Retainer 3-3	Upper ☐	Lower ☐

Alignment Required

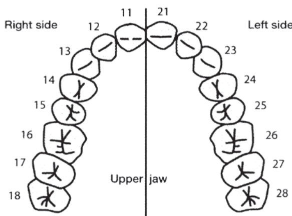


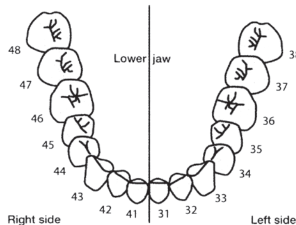
Canines can only be moved distally

Degree of Crowding (if known)

Upper_______mm Lower_______mm NB. Divide IPR evenly between incisors and canines

Further Instructions





Signature ______________________________ **License #** ______________________

Doctor's email address ____