PREMIERE DENTAL

iTero DIGITAL PRACTICE

Invisalign Request Form

Patient: _____ **Date:** _____

Providing Dentist: _____

Case Type: Invisalign / Completion / Revision

Cost: _____

Treatment Goals:

_____
_____
_____
_____
_____

Signature of Providing Dentist: _____

Form must be filled out by treating provider, once completed and ordered, the provider is to give to the front desk to scan into the patient document center.

****Payment must be collected IN FULL before submitting form*****