

(770) 928-4481

DOCTOR _____

ADDRESS _____

_____ ZIP _____

PHONE (____) _____

DATE DUE _____

PATIENT'S NAME _____

APPLIANCE TYPE DESIRED:

Upper _____

Color: _____

Lower _____

CLASPS

- Adams
- Ball
- "C"
- Arrow
- Other _____

Springs _____

Tooth Shade _____

| | | | | | |
|---------------------|---|---|---|---|---|
| Reset teeth circled | | | | | |
| R | 2 | 1 | 1 | 2 | L |
| | 2 | 1 | 1 | 2 | |

NIGHT GUARD / SPLINT

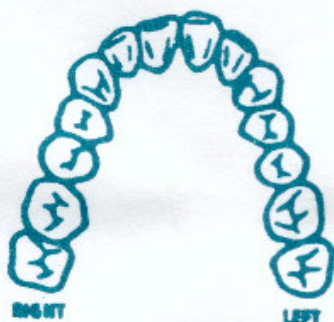
- Upper Smooth Occlusal
- Lower Occlusal Indentations

FIXED APPLIANCES

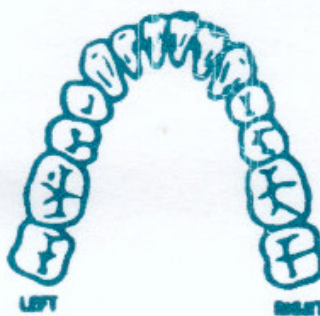
- Upper Lower
- Habit Appliances
- Lingual Arch
- Nance Button
- Pedo Partial
- Quad Helix
- Rapid Palatal Expander
- Space Maintainer
- Other _____

BITE PLATES

- Anterior
- Posterior



UPPER



LOWER

SPECIAL INSTRUCTIONS: _____

DO YOU NEED? Prescription Forms Other