

(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**

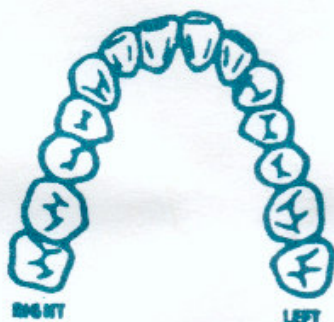
- Upper  Smooth Occlusal
- Lower  Occlusal Indentations

**FIXED APPLIANCES**

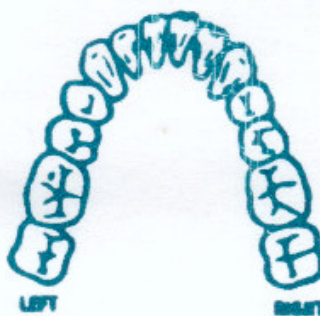
- Upper  Lower
- Habit Appliances
- Lingual Arch
- Nance Button
- Pedo Partial
- Quad Helix
- Rapid Palatal Expander
- Space Maintainer
- Other \_\_\_\_\_

**BITE PLATES**

- Anterior
- Posterior



UPPER



LOWER

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DO YOU NEED?**  Prescription Forms  Other