

FUNCTIONAL and SAGITTAL APPLIANCES

Dr. _____

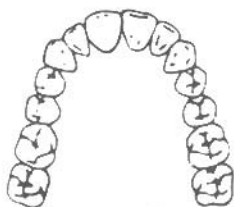
Address _____

City _____ State _____ Zip _____ Ph. 1-() _____

Patient (*Print*) _____

Date of Impression _____

FINISH TIME



R UPPER L



R LOWER L

Remove brackets, if any Yes No

Type appliance _____

BIONATOR:
to open bite _____
to close bite _____
neutral _____

CORRECTOR:
to open bite _____
to close bite _____
neutral _____

SAGITTAL
to move ant. _____
to move post. _____
midline screw? _____

TWIN BLOCK:
to open _____
DIV 1 _____
DIV 2 _____
to close _____
sagittal _____
fixed _____
stage II _____

CONSTRUCTION BITES:
Mount exactly
to wax bite _____
Other _____

◀ Please describe.
P-TYPE ?# _____
BG-TYPE ?# _____
W-TYPE ?# _____
FRANKELS ?# _____

WE NEED Rx's:
 Func. Splints
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Dr. Sig. _____ Lic. # _____ Date _____

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