OCCLUSAL SPLINTS

Dr. _____

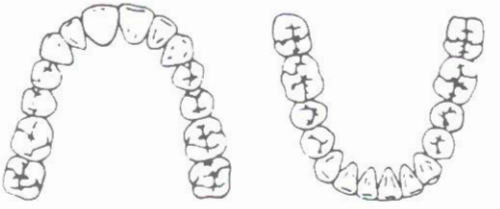
Address _____

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

Patient *(Print)* _____

Date of Impression _____

FINISH TIME



R UPPER L R LOWER L

Remove brackets, if any ☐ Yes ☐ No

☐ Mount exactly to wax bite ☐ Other (Please describe below)

Type appliance _____

SPLINTS:
- Mand. ?_____
- Max. ?_____
- with clasps _____
- without clasps _____

BRUXISM: _____
- TMJ with cusp. rise _____

GELB _____

MORA _____

TANNER _____

WITZIG _____

OTHER TMJ _____

◀Please diagram and describe.

SURGICAL:
- with wire _____
- with lig. holes _____
- both _____

PROFORM (Soft):
- athletic _____
- Nite Guard _____

WE NEED Rx's

☐ Func. ☐ Splints
☐ Stdy. Mdls. ☐ Ret.
☐ Mailing Boxes
☐ Fed Ex Air Bills
☐ Priority Mailers

Dr. Sig. _____ Lic. # _____ Date _____

Dockstader
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