

REMOVABLE and FIXED APPLIANCES

Dr. _____

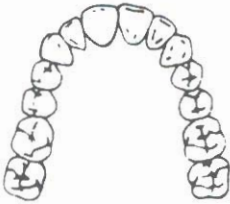
Address _____

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 _____

MAX. ? _____
 Fixed ? _____
 Removable ? _____
 MAND. ? _____
 Fixed ? _____
 Removable ? _____

BITE PLANES:
 No ? _____
 Yes ? _____
 Ant. _____
 Post. _____
 Mount Exactly
 to wax bite _____
 Other _____

◀ Please describe.
 TEETH TO ADD, if any
 # _____

Bio Tone Sh. _____
 COLOR
 Standard Clear
 Blue Yellow
 Green Red
 DECALS
 Boy _____
 Girl _____

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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