

FUNCTIONAL APPLIANCE / PRESCRIPTION



<input type="checkbox"/> PHONE ME CONCERNING THIS CASE <input type="checkbox"/> SPECIAL INSTRUCTIONS ON FILE <input type="checkbox"/> INSURANCE <input type="checkbox"/> ORTHODONTIC STUDY MODELS <input type="checkbox"/> DUPLICATE CASTS	PLEASE SEND: <input type="checkbox"/> Rx SHEETS <input type="checkbox"/> MAILING LABELS <input type="checkbox"/> SHIPPING BOXES <input type="checkbox"/> OTHER _____
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Dr. _____

Address _____

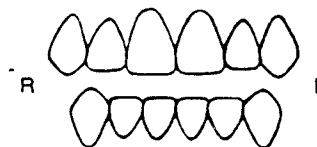
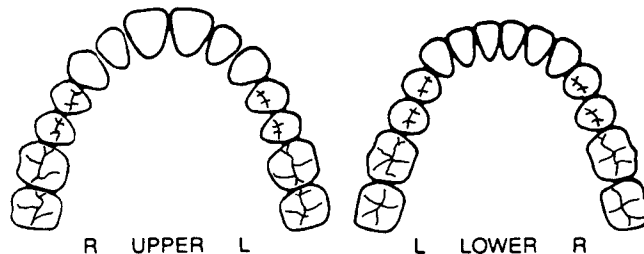
City _____ Province _____ Postal Code _____

Phone (_____) _____

Patient _____

Date Shipped _____

Date Needed _____



INDICATE DENTAL MIDLINE

<input type="checkbox"/> Bio Finisher <input type="checkbox"/> Day Time Appliance <input type="checkbox"/> or Regular	<input type="checkbox"/> Buccal Wires Fixed <input type="checkbox"/> Spring Loaded Screw <input type="checkbox"/> Bio Sagittal	<input type="checkbox"/> Removable <input type="checkbox"/> Full Acrylic Cut <input type="checkbox"/> Braided Strengthener
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ACTIVATOR TYPE _____

BIONATOR	<input type="checkbox"/> To Open Bite <input type="checkbox"/> To Close Bite <input type="checkbox"/> To Maintain
CORRECTOR	<input type="checkbox"/> To Open Bite <input type="checkbox"/> To Close Bite <input type="checkbox"/> To Maintain
MIDLINE SCREW	<input type="checkbox"/> Yes <input type="checkbox"/> No
CORRECTOR SCREWS	<input type="checkbox"/> Full Acrylic Cut <input type="checkbox"/> Partial Acrylic Cut <input type="checkbox"/> Braided Strengthener
LABIAL BOW/WIRE	<input type="checkbox"/> Standard Hawley <input type="checkbox"/> Buccinator (Balters) <input type="checkbox"/> Other (Please diagram)
ERUPTION FACETS	<input type="checkbox"/> Standard – Vertical with Buccal Guidance <input type="checkbox"/> Trim for Maximum Eruption <input type="checkbox"/> Trim as illustrated (Please diagram)
INCISAL CAP	<input type="checkbox"/> Standard <input type="checkbox"/> No Wax Relief or Trimming <input type="checkbox"/> Minimal Labial Coverage <input type="checkbox"/> No Indexing of Upper Incisors
LOWER LINGUAL FLANGES	<input type="checkbox"/> Standard Depth <input type="checkbox"/> Deeper Extensions (Please mark casts)

SAGITTAL	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> To Distalize Posterior <input type="checkbox"/> To Advance Anterior <input type="checkbox"/> 3-Way <input type="checkbox"/> CL III
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SCHWARTZ	<input type="checkbox"/> Upper <input type="checkbox"/> Lower
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BIO BLOCK	<input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV
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CLASPS:
 Indicate location on diagram using the following legend:
 A = Adams Clasps AR = Arrow Head
 B = Ball Clasps O = Other (Please diagram)
 C = "C" Clasps

ACRYLIC COLOR: (Refer to shade guide)	<input type="checkbox"/> Clear Anterior/Pink Posterior <input type="checkbox"/> Clear <input type="checkbox"/> Pink Tint <input type="checkbox"/> Other _____
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HEADGEAR ATTACHMENTS	Indicate Location on Diagram <input type="checkbox"/> .051 <input type="checkbox"/> .045 <input type="checkbox"/> Hooks
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OTHER	<input type="checkbox"/> Labial Pads <input type="checkbox"/> Tongue Crib <input type="checkbox"/> Pearl
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Carve Brackets/Bands off models	<input type="checkbox"/> Yes <input type="checkbox"/> No
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SPECIAL INSTRUCTIONS: _____



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