

DOCTOR \_\_\_\_\_ ACCT# \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE SHIPPED \_\_\_\_\_ DATE NEEDED\* \_\_\_\_\_

*\*Date needed should be at least 1 day before appointment date.*
 APPROVAL TO CHARGE EXPRESS SHIPPING TO RETURN ON DATE NEEDED

**DIGITAL SCAN TAKEN WITH:**
 iTero®  Carestream  CEREC

 TRIOS®  Medit  Other \_\_\_\_\_

## REPOSITIONING SPLINTS

	UPPER	LOWER
Anterior Repositioning Splint (ARS)	<input type="checkbox"/>	
Superior Repositioning Splint (SRS)	<input type="checkbox"/>	<input type="checkbox"/>
NTI Splint 4-4	<input type="checkbox"/>	
MORA (Gelb Design)		<input type="checkbox"/>
Michigan Cuspid Rise	<input type="checkbox"/>	<input type="checkbox"/>
Damon® Stabilizing Design	<input type="checkbox"/>	<input type="checkbox"/>

## FLAT OCCLUSAL SPLINTS

	UPPER	LOWER
Flat Plane Splint	<input type="checkbox"/>	<input type="checkbox"/>
Balanced Occlusal Splint	<input type="checkbox"/>	<input type="checkbox"/>
Dual Laminate Splint	<input type="checkbox"/>	<input type="checkbox"/>
Brux Appliance - Hard Acrylic	<input type="checkbox"/>	<input type="checkbox"/>
Brux Appliance - Soft Vinyl	<input type="checkbox"/>	<input type="checkbox"/>
Deprogrammer	<input type="checkbox"/>	<input type="checkbox"/>
Kois Deprogrammer	<input type="checkbox"/>	

## MOUTHGUARD

	UPPER	LOWER
<input type="checkbox"/> Add Mouthguard	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clear <input type="checkbox"/> Black <input type="checkbox"/> Blue <input type="checkbox"/> White <input type="checkbox"/> Red <input type="checkbox"/> Green		

### SPECIAL INSTRUCTIONS

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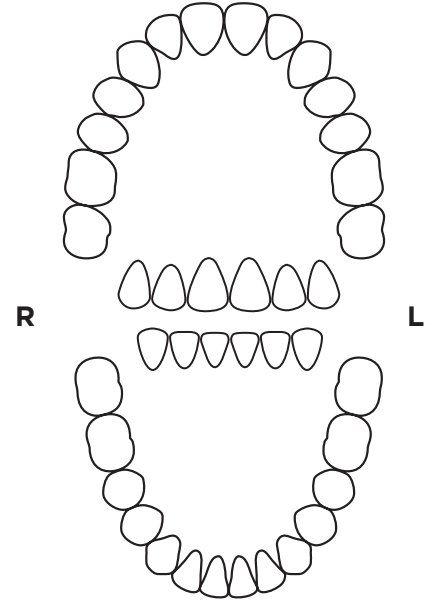
DOCTOR SIGNATURE \_\_\_\_\_

License # \_\_\_\_\_ Expiration \_\_\_\_\_

**OFFICE USE:** 1 2 3 4 + PD: SA DR

**MODELS:** U L BOTH BANDS CROWNS BROKEN

**IMPRESSIONS:** U L BOTH

**DISINFECT:** \_\_\_\_\_ **QA IN:** \_\_\_\_\_ **FINAL INSP:** \_\_\_\_\_


## SPLINT CONSTRUCTION

- Use Enclosed Wax Bite
- Advance Mandible \_\_\_\_\_ mm
- Open \_\_\_\_\_ mm
- Index Posterior
- Anterior Contact Only

## ACCESSORIES

	UPPER	LOWER
<b>WIRE CLASPS</b>		
Lingual Reinforcement	<input type="checkbox"/>	<input type="checkbox"/>
Labial Bow	<input type="checkbox"/>	<input type="checkbox"/>
Ball Clasps	<input type="checkbox"/>	<input type="checkbox"/>
Adams Clasps	<input type="checkbox"/>	<input type="checkbox"/>
C-Clasps	<input type="checkbox"/>	<input type="checkbox"/>
<b>ACRYLIC OPTIONS</b>		
Variflex® Acrylic	<input type="checkbox"/>	<input type="checkbox"/>
Acrylic Color - U _____	<input type="checkbox"/>	
Acrylic Color - L _____		<input type="checkbox"/>