Specialty Appliances™

Digital Services Rx

DOCTOR _____ ACCT# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

PATIENT NAME _____

DATE SHIPPED _____ DATE NEEDED* REQUIRED

**Date needed should be at least 1 day before appointment date.*

◯ APPROVAL TO CHARGE EXPRESS SHIPPING TO RETURN ON DATE NEEDED

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:**_____

DIGITAL SCAN TAKEN WITH:
◯ iTero® ◯ Carestream ◯ CEREC
◯ TRIOS® ◯ Medit ◯ Other_____

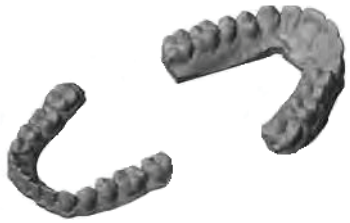
PRINTED MODEL SERVICE

Send us an electronic file (.stl) and we will provide printed models

Horseshoe Base

Upper Qty _____

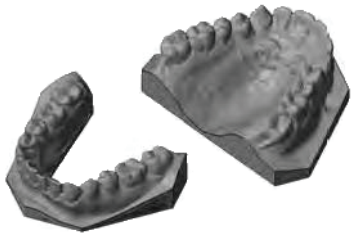
Lower Qty _____



Low Profile Base

Upper Qty _____

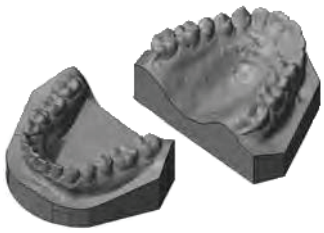
Lower Qty _____



Full Profile Base

Upper Qty _____

Lower Qty _____



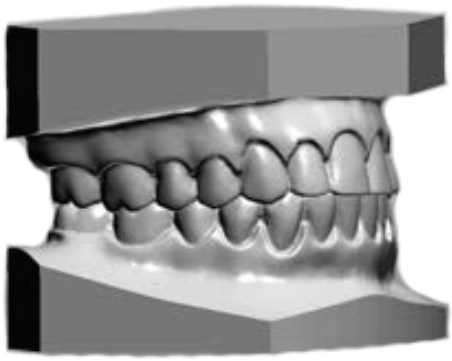
DIGITAL STUDY MODELS

Sent electronically as an .stl file

☐ **Sending in stone models or impressions** and would like to recieve a Full Finish Based

Upper Qty _____

Lower Qty _____



SPECIAL INSTRUCTIONS

DOCTOR SIGNATURE s/

License # REQUIRED Expiration mm/yy

(800) 522-4636
www.specialtyappliances.com

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