

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 EXPEDITED MANUFACTURING & SHIPPING**

DIGITAL SCAN TAKEN WITH:

☐ iTero® ☐ Carestream ☐ CEREC ☐ TRIOS® ☐ Medit ☐ Other _____

SURGIARCH SURGICAL WIRE

SELECT ARCH:

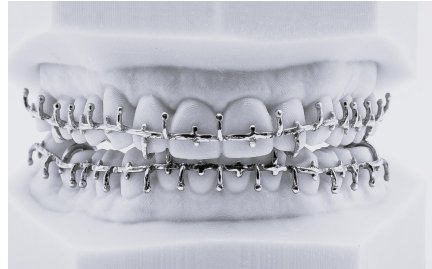
☐ Dual Arch ☐ Upper Only ☐ Lower Only

DESIGN OPTIONS:

☐ Move lower anterior wire lingual due to deep bite
☐ Make sectional surgical wires-diagram

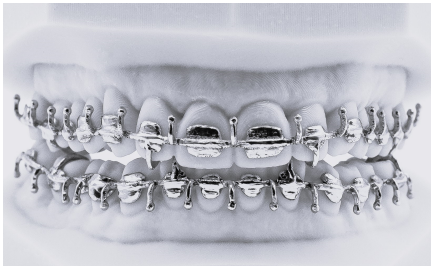
SELECT DESIGN:

☐ X-Bar ☐ Cross Bar



☐ Mesh Pad Base

☐ Perforated Mesh Pad Base



SPECIAL INSTRUCTIONS (Please describe treatment goals and patient chief complaint in detail)

DOCTOR SIGNATURE _____

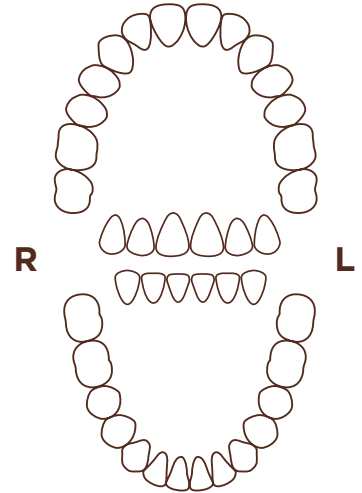
License # _____ Expiration _____

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:** _____



ACCESSORIES

ADD HOOKS PER DIAGRAM

UR ———— UL
 7 6 5 4 3 2 1 1 2 3 4 5 6 7
 LR ———— LL

3D PRINTED BANDS

ADD BANDS PER DIAGRAM

R

7	6	5/e	4/d
7	6	5/e	4/d

 |

d/4	e/5	6	7
d/4	e/5	6	7

 L

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