

**REMOVABLE APPLIANCE
PRESCRIPTION**



Great Lakes Orthodontics, Ltd.
200 Cooper Avenue, Tonawanda, N.Y. 14150
Toll Free: 800-828-7626

PLEASE PRINT

Account # LO _____ **PO #** _____

BILLING PRACTICE TYPE: _____
(i.e., ortho, GP, pedo, prosth, oral surgeon, commer. lab)

DOCTOR: _____

ADDRESS: _____
(Specify if ship to address is different)

ADDRESSES CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____
Provide Country & City Code

FAX: (_____) _____

EMAIL: _____

PATIENT: _____ AGE: _____

PLEASE PRINT

DATE SHIPPED: _____

DATE DUE: _____
1 day before appointment

LAB USE ONLY Incoming # cases 1 2 3 4 5+

Customer Used: GLO Acct 2 Day On Call

Portal Upload - No Frt (99) Cust Acct - No Frt (99)

Disinfected 0 1 2 3 4 5 6 7 8 9

Rcvd: _____

B# _____ Via: _____

QC: _____ LPD/Shp: _____

Needs DD Call Rec: _____

NO BITE / MDL - B / C Doc# _____

Align ID# _____ Dig ID# _____

Please Provide: Boxes Labels

Rx: _____ Qty: _____
(specify appliance type)

Appliance Protection Program (additional fee)

IMPORTANT! Always retain models and bite until appliance is seated.
Damage to models may occur during fabrication, please mark Rx if duplication (additional fee) of model(s) is required.

When forwarding a Removable appliance to the laboratory, we suggest the opposing arch should be included with any case where occlusal interference of clasps is a concern.

Appliance Options Upper Lower Both (Please specify)

Labial Bow: Hawley 3 x 3 Wraparound Soldered to Clasp
 Add 2 x 2 Acrylic QCM Other: _____

Clasps: Adams Circumferential Ball Arrow Buccal Tube
 Occlusal Rest Finger Sage Delta

Springs: Finger "S" Soldered Mousetrap Crossover
 Mushroom Other: _____

Placement of spring as noted (1-32):
UPPER- Indicate Tooth # (s)- _____
LOWER- Indicate Tooth # (s)- _____

Expansion Screws:

Standard Spring Loaded Open Three Way Fan Type
 One Tooth Micro (requires screwdriver) Micro Screwdriver

Auxiliaries: Plastic Pontic; Manufacturer Name _____
Shade # _____

Habit Crib: Loops Spurs

Option: Brackets or Lingual Retainer: Remain Please Carve

Bite Planes: Provide opposing arch if articulation required
 Anterior Posterior Incline

Master Rx on File # _____

Special Instructions: _____

Other Appliance Choices

Tremont Cantilever Wraparound
 ClearBow™

Invisible Retainer:

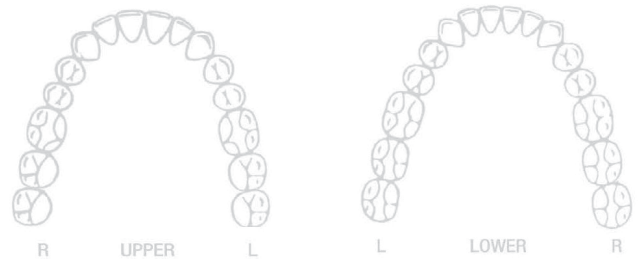
Appliance Options Upper Lower Both (Please specify)
 Essix® Design .75mm (3 x 3 coverage only)
 Invisible Retainer 1mm (Full arch coverage)
 Scallop Trim Marginal Trim

Visit our online appliance catalog at MyGreatLakesLab.com
for a wide variety of color and pattern options!

The standard color is "Clear" unless otherwise specified-

Biocryl Pattern Glitter Decal Rainbow Tropical Tones
 Contemporary Neon Glow Galaxy Glitter MagiCryl®2

Please specify color and/or decal # choice: _____



Lab Use Only:

Base Dup DC Resets Pontics Solder
 Art Sam II Sam III D Pan

License #: _____

Dr. Signature: _____