



Orthodontic Rx



Dr. _____ Location _____

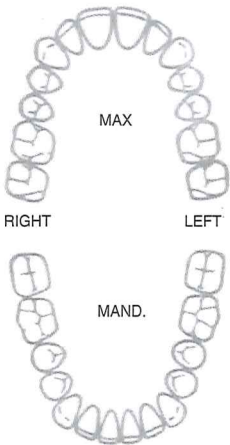
Patient _____ Rx Date _____

Age _____ Sex M / F _____ Due Date _____

Functionals	Expansion	Mx.	Mn.	Fixed Expanders	Mx.	Mn.	Fixed / Rem	Mx.	Mn.
Bionator <input type="checkbox"/>	Sagittal Anterior <input type="checkbox"/>			RPE (Hyrax) <input type="checkbox"/>			Lingual Arch <input type="checkbox"/>		
Activator <input type="checkbox"/>	Prosterior <input type="checkbox"/>			Bonded RPE <input type="checkbox"/>			Transpalatal Arch <input type="checkbox"/>		
Bio-Finisher <input type="checkbox"/>	3-Way-Bertoni <input type="checkbox"/>			Super Screw RPE <input type="checkbox"/>			Nance <input type="checkbox"/>		
Frankel 1,2,3 <input type="checkbox"/>	Schwartz 1 Screw <input type="checkbox"/>			Hass <input type="checkbox"/>			Habit Appliance <input type="checkbox"/>		
Twin Block <input type="checkbox"/>	2 Screw <input type="checkbox"/>			Modified Greenfield <input type="checkbox"/>			Ric-a-nator <input type="checkbox"/>		
Thermanator <input type="checkbox"/>	Acrylic Pads <input type="checkbox"/>			Other: <input type="checkbox"/>			Quad Helix <input type="checkbox"/>		
Other: <input type="checkbox"/>	Anterior / Posterior <input type="checkbox"/>						Space Maintainer (B&L) <input type="checkbox"/>		
	Other: <input type="checkbox"/>						Other: <input type="checkbox"/>		

Retainer	Mx.	Mn.	Splints	Mx.	Mn.	Miscellaneous	Ceph Analysis
Hawley Ret. <input type="checkbox"/>			Bruxism <input type="checkbox"/>			Indirect Bracket Set up <input type="checkbox"/>	MacNamara <input type="checkbox"/>
Wraparound Ret. <input type="checkbox"/>			TMJ <input type="checkbox"/>			Transfer Tray <input type="checkbox"/>	Rondeau <input type="checkbox"/>
Spring Retainer <input type="checkbox"/>			Gelb <input type="checkbox"/>			3-3 Soldered <input type="checkbox"/>	Steiner <input type="checkbox"/>
Essix <input type="checkbox"/>			NTI <input type="checkbox"/>			3-3 Wire <input type="checkbox"/>	Sassouni <input type="checkbox"/>
Spring Aligner <input type="checkbox"/>			Deprogrammer <input type="checkbox"/>			Elastics <input type="checkbox"/>	Bimler <input type="checkbox"/>
Van Der Linder <input type="checkbox"/>			Day time Orthotic <input type="checkbox"/>			Single Buccal Tubes <input type="checkbox"/>	Study Models
Canterlever <input type="checkbox"/>			Night time Orthotic <input type="checkbox"/>			Double Buccal Tubes <input type="checkbox"/>	Finished <input type="checkbox"/>
QCM <input type="checkbox"/>			Other: <input type="checkbox"/>			Triple Buccal Tubes <input type="checkbox"/>	Rough Trim <input type="checkbox"/>
Other: <input type="checkbox"/>						Wilson Attachments <input type="checkbox"/>	

Colour	Material Choice	Have you sent the following
Clear <input type="checkbox"/>	Hard Acrylic <input type="checkbox"/>	Impression U L <input type="checkbox"/>
Standard Pink <input type="checkbox"/>	Thermaflox <input type="checkbox"/>	Model U L <input type="checkbox"/>
Standard Blue <input type="checkbox"/>	ImPak PF <input type="checkbox"/>	Bite Registration <input type="checkbox"/>
Customized <input type="checkbox"/>	Dual Laminate <input type="checkbox"/>	Olmos Articulation <input type="checkbox"/>
Colour _____	Biocryl <input type="checkbox"/>	Request Form <input type="checkbox"/>
Logo _____		Call me to discuss <input type="checkbox"/>
		Prepare consultation <input type="checkbox"/>



Toll Free: 1-800-265-4052
Local 519-539-2065
Fax 519-537-7794

Dr. Signature _____

63 Ridgeway Circle
Woodstock, Ontario J
N4V 1C9

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