



— VANCOUVER —

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DOCTOR'S NAME _____ ACCT #: _____

CITY _____ PROV. _____

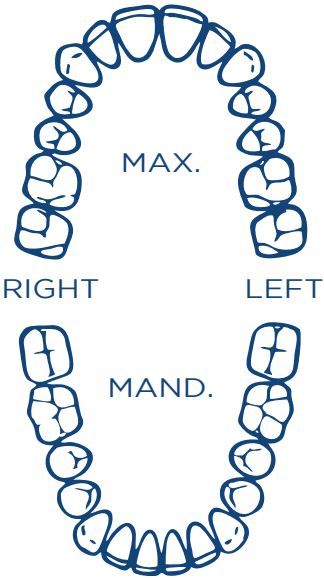
TELEPHONE () _____ TODAY'S DATE _____

PATIENT'S FULL NAME (Important - Please Print)

AGE

PLEASE CHECK SHOULD YOU WISH TO HAVE THE FOLLOWING
DUPLICATE MODELS **ORTHO STUDY MODELS** **Date of Birth**
WORKING MODELS TRIM ONLY SOAPED

DATE REQUIRED:



- | MAX. | MAND. | APPLIANCE TYPE |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | SPLINT <input type="checkbox"/> GELB. |
| <input type="checkbox"/> | <input type="checkbox"/> | CLEAR-FLEX® SPLINT |
| <input type="checkbox"/> | <input type="checkbox"/> | DUAL-FLEX® SPLINT |
| <input type="checkbox"/> | <input type="checkbox"/> | PRO-FORM™ NITE GUARD |
| <input type="checkbox"/> | <input type="checkbox"/> | SCHWARZ |
| <input type="checkbox"/> | <input type="checkbox"/> | SAGITTAL |
| <input type="checkbox"/> | <input type="checkbox"/> | BLEACHING TRAYS |

RETAINERS

- | | | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | STANDARD |
| <input type="checkbox"/> | <input type="checkbox"/> | WRAP AROUND |
| <input type="checkbox"/> | <input type="checkbox"/> | FLAT LABIAL |
| <input type="checkbox"/> | <input type="checkbox"/> | SAN ANTONIO |
| <input type="checkbox"/> | | SPORTS FLEX MOUTHGUARD |
| <input type="checkbox"/> | <input type="checkbox"/> | MULTI |
| <input type="checkbox"/> | <input type="checkbox"/> | REG |
| <input type="checkbox"/> | <input type="checkbox"/> | SUPER |
| <input type="checkbox"/> | <input type="checkbox"/> | MARTIAL ARTS |

FUNCTIONAL APPLIANCES

- BIONATOR OPEN CLOSE
 ORTHOPEDIC CORRECTOR OPEN CLOSE
 FRANKEL NO. _____
 CLARK TWIN BLOCK TYPE MAX. MAND.

FIXED APPLIANCES MAX. MAND.

- BONDED HAAS
 BONDED HYRAX
 BANDED HYRAX

R _____

PLEASE CHECK SHOULD YOU WISH TO HAVE THE FOLLOWING
 Insurance Program Passport to a Healthy Smile