

The Wirebenders

An Orthodontic Laboratory (408) 265-5576

16230 Monterey Road • Suite 200 • Morgan Hill, CA 95037

www.thewirebenders.com

DOCTOR: _____

DATE SENT TO LAB: _____

ADDRESS: _____

DATE NEEDED: _____

PHONE: _____

PATIENT NAME or ID: _____

UPPER LOWER REMOVEABLE APPLIANCES

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Standard Hawley
Wraparound Hawley
Expansion Appliance * list type

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

INVISIBLE RETAINERS (ESSIX)

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

3D MODELS from your stl file

FIXED APPLIANCES

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

4-Leg Expansion Appliance
2-Leg Expansion Appliance
Nance Appliance
Lingual Arch (6-6)
Habit Appliance
Arnold
Quad Helix
Space Maintainer

ACCESSORIES/EXTRAS

****Draw where wanted****

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Circumferential Clasps
Adams Clasps
Ball Clasps
"C" Clasps
Habit Loops
Springs * list type
BANDS *indicate tooth to be banded*
Band on tooth #(s): _____
Plain or with Tubes: _____

BITE PLANE

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Anterior
Posterior

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

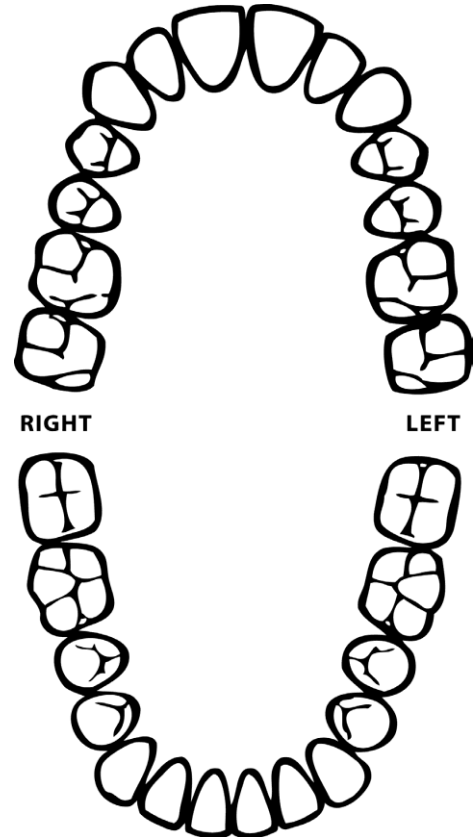
HARD NIGHT GUARD/SPLINT

NOTES or OTHER APPLIANCES NOT LISTED:

DESIGN CASE HERE

Indicate extent of acrylic, clasp, and spring location.

UPPER COLOR: _____



RIGHT

LEFT

LOWER COLOR: _____

I (the Doctor) upon receipt of the above prescribed appliance, assume all responsibility of inspection for correctness and intended use.

Doctors Signature: _____

License #: _____

**PLEASE CHECK ALL MODELS/SCANS FOR DISTORTION
PRIOR TO SENDING TO LAB, AS WE CAN ONLY
FIT APPLIANCE TO WHAT IS SENT TO LAB.**