

STUDY MODEL PRESCRIPTION

DR. NAME _____ ACCT. # _____

ADDRESS _____ PHONE # _____

LICENSE # _____ FAX # _____

DATE SENT - -

DATE WANTED - -

(2 days prior to insertion)

- Complete Models** (from impressions) - Pour, Trim, Sculpture, Print, Polish
- Complete** (to be duplicated) - Duplicate models provided, Pour, Trim Sculpture, Print, Polish
- Complete Models** (poured casts enclosed) - Trim if needed, Sculpture, Print, Polish
- Thru Label** - Pour, Trim, Sculpture, Print (no polish)
- Progress Models** - Pour, Rough-Trim, Pencil Label
- Board Models** - Pour, Trim, Sculpture, Polish

TRIMMING:

- 2-3/4" (standard height) Trim to Centric
- Proportion
(1/3 base, 2/3 anatomy) Use Wax Bite Remove Brackets

IMPRINT:

(Patient's Last Name)


DOB - -

(Patient's First Name)


CASE#

IMPRESSION DATE - -


PATIENT NAME
DATE



STANDARD



INDICATE CUSTOM



PATIENT NAME



- | | | | | |
|---|---|--|-------------------------------------|--|
| <input type="checkbox"/> Standard Rx | <input type="checkbox"/> Frankel Rx | <input type="checkbox"/> Labels | <input type="checkbox"/> Boxes | <input type="checkbox"/> Color Chart |
| <input type="checkbox"/> Study Model Rx | <input type="checkbox"/> Twin Block™ Rx | <input type="checkbox"/> Splint Rx | <input type="checkbox"/> Pkg Foam | <input type="checkbox"/> Star Aligner Rx |
| <input type="checkbox"/> C/B Rx | <input type="checkbox"/> Herbst® Rx | <input type="checkbox"/> Impression Bags | <input type="checkbox"/> Price List | <input type="checkbox"/> |



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