REPAIR/REMAKE PRESCRIPTION

DR. NAME______________________________________ ACCT. # ____________________

ADDRESS______________________________________ PHONE # ____________________

LICENSE #_____________________________________FAX # ____________________

PATIENT'S NAME____
(please print) (Last) (First)

DATE SENT__________________________DATE WANTED__________________________
(2 days prior to insertion)

Our Promise of Quality ....
Any appliance found to contain defective components or show faulty construction within 90 days of delivery will be repaired or replaced at no charge. Clearly note the problem areas for our technical supervisor to review.

ITEM RETURNED: ____

CONDITION: _______one piece _____multiple pieces _____pieces missing

MODEL SUPPLIED: _______original _____new model _____no model

EXPECTATION: _______REPAIR. I realize it may not fit the model due to adjustments, wear, etc. ($10 shipping/handling fee applies)

_______LOOK LIKE NEW, adding new wires or acrylic to fit the model provided. (percentage charge based on amount of processing needed)

_______PLEASE REVIEW, as I feel this may qualify for a FREE replacement.

COMMENTS:

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