

SPLINT PRESCRIPTION

DR. NAME _____ ACCT. # _____

ADDRESS _____ PHONE # _____

LICENSE # _____ FAX # _____

PATIENT'S NAME _____
(please print) (Last) (First)

DATE SENT _____ DATE WANTED _____
(2 days prior to insertion)

Invisible Vacuum Retainer U or L

Invisible Retainer w/Resets

Hard/Soft Vacuum Splint U or L

RESET: R 3 2 1 | 1 2 3 L

Soft Splint U or L

R 3 2 1 | 1 2 3 L

Thermal Talon® Splint U or L

Special rush — patient in pain!

Bleaching Trays U or L

Clasp — ball clasps standard

Athletic Mouthguard U or L

Clasp — alternate _____

Palate — horseshoe or full

Anterior Repositioning
Splint —

ramp to hold forward position



Lower Repositioning
Splint —

deep incising of upper cusps



Full coverage/contact
Splint —

(upper or lower)



Gelb Splint —

lingual bar, contact with
upper lingual cusps



Tanner Splint —

Gelb type with
anterior reverse bite ledge



Sved Plate —

coverage over molars; anterior
bite plane with slight guidance ramp



Ortho Rx

Frankel Rx

Labels or Boxes

Pkg Foam

Study Model Rx

Twin Block™ Rx

Splint Rx

Price List

C/B Rx

Herbst® Rx

Color Chart