

Please Complete This Form
in Full to Expedite Your Order

LAB USE

DATE OUT _____

TECHNICIAN _____

Dr. Name _____

Date Patient is Scheduled _____

Address _____

* Schedule your patient
at least 14 days from today

Phone _____

* Please call in advance
for rush cases

Patient Name _____

1. Bruxism/TMD Splints

	UPPER	LOWER
SOFTOUCH	<input type="checkbox"/>	<input type="checkbox"/>
FLEXI-GUARD	<input type="checkbox"/>	<input type="checkbox"/>
HARD-GUARD	<input type="checkbox"/>	<input type="checkbox"/>
SOFT GUARD	<input type="checkbox"/>	<input type="checkbox"/>
GELB		<input type="checkbox"/>
MODIFIED GELB		<input type="checkbox"/>
PANKEY SPLINT	<input type="checkbox"/>	<input type="checkbox"/>
DAWSON SPLINT	<input type="checkbox"/>	<input type="checkbox"/>
OTHER _____		

2. Indicate Splint Design

Check all that apply:

FLAT PLANE/ GROUP FUNCTION	<input type="checkbox"/>
CUSPID RISE	<input type="checkbox"/>
ANTERIOR GUIDANCE	<input type="checkbox"/>
INDENT CUSPS	<input type="checkbox"/>
SCALLOP	<input type="checkbox"/>
CR BITE INCLUDED	<input type="checkbox"/>
MI BITE INCLUDED	<input type="checkbox"/>

3. Indicate Palatal Design

HEIGHT OF CONTOUR	<input type="checkbox"/>
HORSESHOE	<input type="checkbox"/>
THREE-QUARTER	<input type="checkbox"/>

4. Fit

TIGHT	<input type="checkbox"/>
FIRM	<input type="checkbox"/>
LOOSE	<input type="checkbox"/>

5. Retention

BALL	<input type="checkbox"/>
C CLASPS	<input type="checkbox"/>
ADAMS	<input type="checkbox"/>
OTHER _____	<input type="checkbox"/>

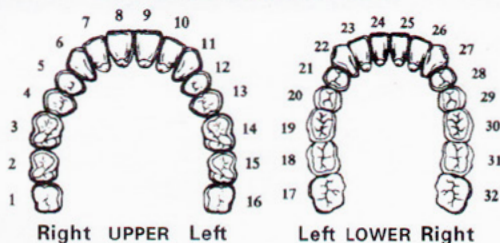
PLEASE SEND:

AIRBILLS BOXES Rx's

Rx Date _____

Dentist Signature/License # _____

DIAGRAM APPLIANCE BELOW



6. Orthodontic/Misc.

DREAM TAP™ APPLIANCE	<input type="checkbox"/>	(Treatment of Sleep Apnea)
SNORNOMOR	<input type="checkbox"/>	(Not indicated for Sleep Apnea)
BLEACHING TRAYS	<input type="checkbox"/>	Upper <input type="checkbox"/> Lower <input type="checkbox"/>
HAWLEY	<input type="checkbox"/>	Upper <input type="checkbox"/> Lower <input type="checkbox"/>
	<input type="checkbox"/>	Ant. Bite Plane
	<input type="checkbox"/>	Post. Bite Plane
BIOCRYL CLEAR RETAINER	<input type="checkbox"/>	Upper <input type="checkbox"/> Lower <input type="checkbox"/>
PROFORM ATHLETIC GUARD	<input type="checkbox"/>	3mm <input type="checkbox"/> 5mm <input type="checkbox"/>
	<input type="checkbox"/>	Clear <input type="checkbox"/> Color _____
FLUORIDE TRAYS	<input type="checkbox"/>	Upper <input type="checkbox"/> Lower <input type="checkbox"/>
BRITE TOUCH™ SPLINT CLEANER	<input type="checkbox"/>	
AQUALIZER 10 PACK	<input type="checkbox"/>	

7. Special Instructions

CALL ME

 Annalan
LABORATORY

The Difference is Clear

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