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TORONTO

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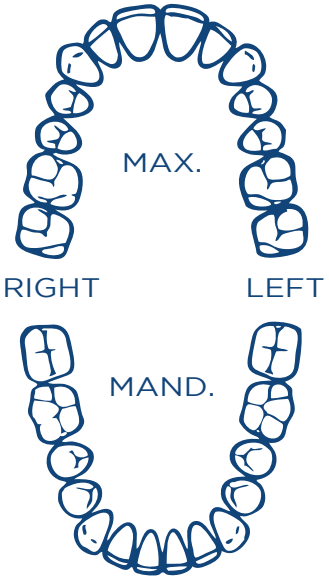
DOCTOR'S NAME _____

CITY _____ PROV. _____

TELEPHONE ( ) _____ TODAY'S DATE _____

PATIENT'S FULL NAME (Important - Please Print) AGE

DUPLICATE MODELS ☐ **STUDY MODELS** ☐ PLASTIC BASED ☐ SCULPTURED (PLASTER)



DATE REQUIRED: ☐

MAX.	MAND.	APPLIANCE TYPE
☐	☐	SPLINT
☐	☐	CLEAR FLEX
☐	☐	SCHWARZ
☐	☐	SPRING RETAINER
☐	☐	SPORT MOUTHGUARD
	☐	JACKSON
	☐	GELB.
☐	☐	SAGITAL
☐	☐	CROZAT
		RETAINERS
☐	☐	STANDARD
☐	☐	WRAP AROUND
☐	☐	FLAT LABIAL
☐	☐	SAN ANTONIO

FUNCTIONAL APPLIANCES

☐ TWIN BLOCK ☐ No. _____
☐ BIONATOR ☐ OPEN ☐ CLOSE
☐ ORTHOPEDIC CORRECTOR ☐ OPEN ☐ CLOSE
☐ FORESTACRYL ☐ FRANKEL No. _____
☐ BIOBLOCK No. _____ ☐ OPEN ☐ CLOSE
☐ INDIRECT BOND 6-61

℞ _____

PLEASE CHECK SHOULD YOU WISH TO HAVE THE FOLLOWING

☐ Insurance Program ☐ Passport to a Healthy Smile