PRECISE ORTHODONTICS

Doctor _____

Address _____

City & State _____ Zip _____

Telephone ( ) _____

Patient's Name _____

Date shipped by Doctor _____

RETURN DATE _____

PLEASE PRINT PATIENT'S

NAME

NUMBER

DATE

DIAGNOSTIC STUDY MODELS

- ☐ Study Models (complete)
- ☐ Study Models (complete, no soap)
- ☐ Study Models (trimmed only)
- ☐ Second Duplicate Set
- ☐ Permanent Identification
- ☐ Board Models
- ☐ Sam Articulated Models

For Lab Use

Indicate Original Malocclusion: Class _____ **Division** _____

ADDITIONAL INFORMATION _____

P.O. Box 633 Burlington, WI 53105 (262) 767-1440 Toll Free 1-800-517-9424	**PLEASE SEND ADDITIONAL** ☐ Shipping Boxes ☐ Shipping Bags/Labels ☐ Prescription Sheets

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