

SPRING ALIGNER Upper Lower
 Without ext. Wire ext. (2 teeth) Acrylic ext. (2 teeth)

SPRING ALIGNER / HAWLEY COMBINATION Upper Lower

SPRING ALIGNER PLUS Upper Lower
 Original Design 7-7 Mini Design 6-6

HAWLEY RETAINER Upper Lower

Clasps Ball Arrow/Anchor C L Eye
 Adams Other _____

Auxiliaries Springs Mini screw Micro screw

Labial Wire 2-2 3-3 4-4 Wraparound

Clear Bow 3-3 4-4 Wraparound

SAL® (Self Activating Loops)

Add Labial Acrylic Pontic tooth shade _____

ACTIVE APPLIANCES Upper Lower
 Anterior bite plane
 Posterior bite plane

Schwarz 1 screw 2 screws

Sagittal 1 screw 2 screws 3 screws 3-way screw

SPLINTS Upper Lower

Hard acrylic Flat plane Lock in bite

Hard / Soft laminate 2mm 3mm

Soft 2mm 3mm

Gelb

Invisible retainer .030" .040" C+ (.040")

Note: Clasps cannot be placed in soft material.
Please include wax bite or mark bite at desired position on the models.

FIXED APPLIANCES Upper Lower

MAINTAINING / REGAINING

Lingual arch 3-3 4-4 5-5 6-6
 Add soldered stops (indicate where)

Band and Loop Space Maintainer

Nance Holding Arch Space Regainer
 Trans-Palatal Arch

EXPANSION / ARCH DEVELOPMENT

E-Appliance Pendulum

Haas Quad Helix

Hyrax

HABIT

Blue Grass Appliance

Habit Appliance Tongue thrust Finger

INDIRECT SERVICE Upper Lower

Bond-A-Splint® (pads all teeth) 1-1 2-2 3-3 4-4

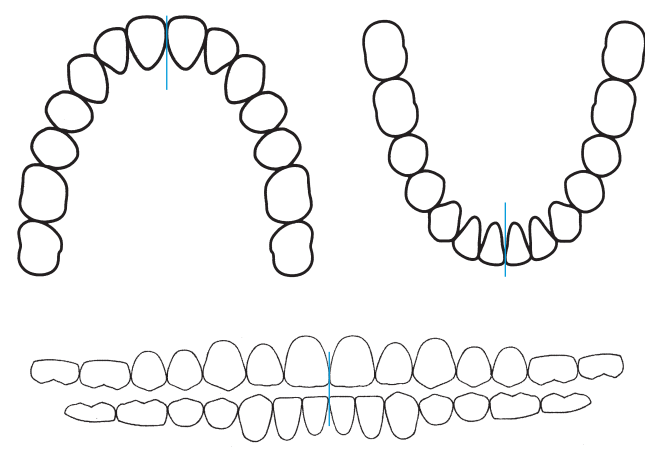
Bondable Lingual Retainer (two pads) 1-1 2-2 3-3 4-4

Bond-A-Bar Periodontal Splint (solid strip) 1-1 2-2 3-3 4-4

Custom (special inst.)

Tray Type Clear No Tray

CUSTOM APPLIANCE Rx



Right ← → Left

Enclosed Scan Impression Model Upper Lower

Remove all attachments from model: Yes No

Duplicate models: Yes No

Return work models: Yes No

STRIP TEETH

None

Strip 0. ___ mm from each tooth at contact points marked.

RESET TEETH

None Over rotate

Compromise Ideal

Reset teeth circled Overcorrect labiolingually

Approve setup

TYPE OF ACRYLIC

Pink Clear

Pastel Palates® Color # _____ Decal # _____

SPECIAL INSTRUCTIONS

Mailing & Shipping
 100 Center Plaza
 La Porte, Indiana 46350-9672 USA
 Phone: 800-348-8856
 219-785-2591

Instructions for digital/online prescription submissions can be found at tportho.com/custom

This is my first case with TP Orthodontics.

ACCOUNT NO. _____

Dr. _____

Address _____

City _____

State _____

Zip _____ Phone _____

E-Mail _____

Patient's Name _____

Date Shipped _____ Date _____
 to TPO _____ Required _____

This custom-made device is manufactured to satisfy the design characteristics and properties specified by the prescribing doctor for this specific patient, and is intended for the exclusive use of the named patient.

SHIPPING

Ground Second Day Overnight First Class

PLEASE DO NOT WRITE IN THIS SPACE			

PLEASE SEND ADDITIONAL SUPPLIES
 (Fill in address label only if additional material requested)

Dr. _____

Address _____

City / State / Zip _____

Appliance Rx Shipping Boxes Shipping Labels

Set-Up & Positioner Rx Shipping Bags

Other _____