

**GENERAL LAB
PRESCRIPTION**



PLEASE PRINT

Account # C0 _____ **PO #** _____

B I L L I N G PRACTICE TYPE: _____
(i.e., ortho, GP, pedo, prosth, oral surgeon, commer. lab)

DOCTOR: _____

ADDRESS: _____
(Specify if ship to address is different)

A D D R E S S CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____

FAX: (_____) _____

EMAIL: _____

PATIENT: _____ AGE: _____

PLEASE PRINT

DATE SHIPPED: _____

DATE DUE: _____
1 day before appointment

LAB USE ONLY Incoming # cases _____

Customer Used: GLO Acct 2 Day On Call

Portal Upload - No Frt (00) Cust Acct - No Frt (00)

Disinfected 0 1 2 3 4 5 6 7 8 9

Rcvd: _____

B# _____ Via: _____

Shipment Date _____ Planned Shipment Date _____

(QC): _____ (LPD): _____

Estimated Delivery Date _____ Promised Delivery Date _____

ND _____ (Rec): _____

NO BITE / MDL - B / C Source: _____

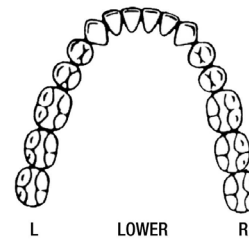
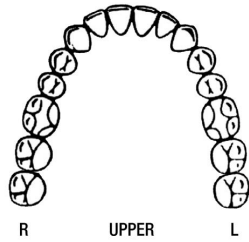
Campaign: _____

Align ID# _____ Dig ID# _____

Please Provide:

Boxes Labels
 Rx (specify appl. type): _____

**IMPORTANT! Always retain models and bite until appliance is seated.
Damage to models may occur during fabrication, please mark Rx if duplication (additional fee) of model(s) is required.**



Color - Decal #

Removable Appliance

- Arch: Upper Lower
- Adams Clasp
 - Arrow Clasp
 - Ball Clasp
 - Buccal Tube Clasp
 - Pontic Shade: _____
 - Circumferential Clasp
 - Bite Plate
 - Expansion Screw
 - Spring: draw or specify type

Spring Aligner

- Arch: UPPER- Right 1 2 / Left 1 2
- LOWER- Right 1 2 / Left 1 2

Color - Decal #

Fixed Appliance

- 3 x 3 4 x 4 5 x 5 6 x 6 - Soldered Lingual Arch
- Space Maintainer
- Rapid Palatal Expander HAAS RPE
- Quad Helix Appliance
- Nance Button Appliance
- Tongue Crib Appliance

Functional Appliance

- Twin Block
- Herbst
- Other _____

Master Rx on File # _____

Special Instructions: _____

License #: _____

Dr. Signature: _____