

OCCLUSAL SPLINTS

Dr. _____

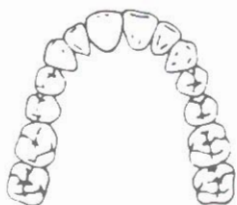
Address _____

City _____ State _____ Zip _____ Ph. 1-() _____

Patient (*Print*) _____

Date of Impression _____

FINISH TIME



R UPPER L R LOWER L

SPLINTS:

- Mand. ? _____
- Max. ? _____
- with clasps _____
- without clasps _____

BRUXISM: _____

- TMJ with
- cusp. rise _____

GELB _____

MORA _____

TANNER _____

WITZIG _____

OTHER TMJ _____

◀ Please diagram and describe.

SURGICAL:

- with wire _____
- with lig. holes _____
- both _____

PROFORM (Soft):

- athletic _____
- Nite Guard _____

WE NEED Rx's

- Func. Splints
- Stdy. Mdls. Ret.
- Mailing Boxes
- Fed Ex Air Bills
- Priority Mailers

Remove brackets, if any Yes No

Mount exactly to wax bite Other (Please describe below)

Type appliance _____

Dr. Sig. _____ Lic. # _____ Date _____

Dockstader

YOUR FULL SERVICE DENTAL LAB



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