

AccuBond™ Indirect Bonding Rx



Dr. _____ Address _____ City & State _____ Tel _____ Fax _____ Email _____	Patient _____ Shipped Date _____ Placement Date _____
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PLEASE SHIP EXTRA: SHIPPING BOXES PRE-PAID BAGS PRESCRIPTION SHEETS

PRESCRIPTION INFORMATION: NOTE: DOCTOR MUST PROVIDE BRACKETS

1. Bracket Type: In-Ovation® R Upper Lower
 In-Ovation® C Upper Lower

2. Bracket Slot Size: .018" .022"

3. Bracket Height: Lab will use standard settings given below, unless prescribed otherwise.

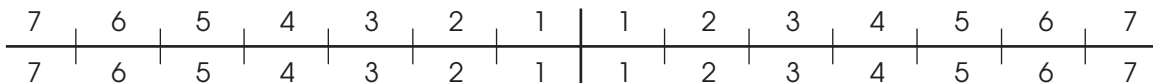
MAXILLARY – Height in mm from incisal edge

Tooth Number	7	6	5	4	3	2	1	1	2	3	4	5	6	7
Prescribed														
Actual <small>(lab use only)</small>														
Hyperdivergent (vertical) Growth	5	5	5	5	5	4.5	4.5	4.5	4.5	5	5	5	5	5
Hypodivergent (horizontal) Growth	4.5	4.5	4.5	4.5	4.5	4	4	4	4	4.5	4.5	4.5	4.5	4.5

MANDIBULAR – Height in mm from incisal edge

Tooth Number	7	6	5	4	3	2	1	1	2	3	4	5	6	7
Prescribed														
Actual <small>(lab use only)</small>														
Standard	4.5	4.5	4.5	4.5	4.5	4	4	4	4	4.5	4.5	4.5	4.5	4.5

4. Circle teeth to be extracted:



a. If extra angulation is desired for abutments, please circle desired angulation in degrees:

0 1 2 3 4 5 6 7 8 9 10 Other: _____

5. Special exceptions, such as impacted or missing teeth: _____

6. Lingual buttons, cleats, or other. List tooth number and positions desired (mesial, distal, gingival): _____

7. Lab to draw bracket placement lines on models.
 Dr. will provide models with bracket placement lines drawn.

PLEASE WRITE SPECIAL INSTRUCTIONS

PLEASE CALL ME ABOUT THIS ORDER

GACOrthoLab orthodontic laboratory services	2525 3 MILE ROAD RACINE, WI 53404	Toll-FREE: (866) 463-4300 Fax: (262) 752-4060	Main Tel: (262) 752-4040 For billing questions: (800) 645-5530
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