



423 South 13th St. • Terre Haute, IN 47807 • 800/457-0504
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JDL Ortho Replacement Program PLEASE SEND General Lab Rx
 JDL Claim Case # Shipping Labels Ortho Rx
 (Removable appliances only) Shipping Boxes Ceph Rx

REMOVABLE ORTHO APPLIANCES

SAGITTAL		EXPANSION		Options:
Upper	Lower	Upper	Lower	
1 Screw <input type="checkbox"/>	<input type="checkbox"/> 1 Screw	<input type="checkbox"/>	<input type="checkbox"/> Transverse (Posterior Pads)	<input type="checkbox"/> Bowbeer
2 Screw <input type="checkbox"/>	<input type="checkbox"/> 2 Screw	<input type="checkbox"/>	<input type="checkbox"/> Schwarz (No Posterior Pads)	<input type="checkbox"/> Truitt Style
3 Screw <input type="checkbox"/>	<input type="checkbox"/> 3 Screw	<input type="checkbox"/>	<input type="checkbox"/> Nord (Unilateral) <input type="checkbox"/> L <input type="checkbox"/> R	
4 Screw <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Fan <input type="checkbox"/> Check for Reverse Fan	
<input type="checkbox"/> Bailey Distal Push Sagittal				
EVANS S-II (Class III)		LOWER JACKSON		TEETH
<input type="checkbox"/> 2 Screw <input type="checkbox"/> 3 Screw		<input type="checkbox"/> Standard <input type="checkbox"/> Truitt Style		Tooth # _____ Shade _____

HAWLEY		Brackets	<input type="checkbox"/> TMJ Patient
UPPER	LOWER	<input type="checkbox"/> Leave On <input type="checkbox"/> Remove	(Use Bite with No Changes)
<input type="checkbox"/> Standard <input type="checkbox"/> Standard	<input type="checkbox"/> Clear labial Bow (QCM)		
<input type="checkbox"/> Wraparound <input type="checkbox"/> Wraparound	<input type="checkbox"/> Star		

SPRING RETAINERS		BIONATOR	
Upper	Lower	<input type="checkbox"/> To Open Bite (I)	Options:
<input type="checkbox"/>	<input type="checkbox"/> Galella Style	<input type="checkbox"/> To Close Bite (II)	<input type="checkbox"/> Stack
<input type="checkbox"/>	<input type="checkbox"/> Palatal/Lingual Acrylic (Hawley Style)	<input type="checkbox"/> To Maintain Bite (III)	<input type="checkbox"/> Mini
<input type="checkbox"/>	<input type="checkbox"/> Anterior Clip		

SPEEDALIGNER®	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	CORRECTOR	BIOFINISHER
VACUFORM	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> To Open Bite (I)	<input type="checkbox"/> To Open Bite
<input type="checkbox"/> Anterior Essix <input type="checkbox"/> Full-Arch Truax <input type="checkbox"/> Star		<input type="checkbox"/> To Close Bite (II)	<input type="checkbox"/> To Close Bite
Specify which teeth to reset: _____		<input type="checkbox"/> To Maintain Bite (III)	Teeth to be erupted: _____

TWIN BLOCK	Please check your preferred design.	OTHER APPLIANCES	
<input type="checkbox"/> Clark Twin Block (Classic Design-Our most popular)	<input type="checkbox"/> McNamara Twin Block (Designed with Lower Cap)	<input type="checkbox"/> Elastodontics	<input type="checkbox"/> Positioner
<input type="checkbox"/> Mahony Twin Block (Cuspid Ramp Design)	<input type="checkbox"/> Broadbent Twin Block (Designed for patient comfort)	<input type="checkbox"/> Spahl Split Vertical	
<input type="checkbox"/> Gerber Twin Block		<input type="checkbox"/> Frankel <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	
		<input type="checkbox"/> S.S. Crozat	<input type="checkbox"/> Upper <input type="checkbox"/> Lower

RECORD MODELS	TMJ & SLEEP APNEA	
<input type="checkbox"/> Soaped / Labeled	TMJ SPLINTS	MATERIAL
<input type="checkbox"/> Unsoaped / Unlabeled	<input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> Thermo Plastic (Clear Splint)
BIRTHDATE: ____/____/____	<input type="checkbox"/> Bailey Distal Push Splint	<input type="checkbox"/> Hard Acrylic
CEPH TRACING	<input type="checkbox"/> Denar/Witzig <input type="checkbox"/> with Night Corrector	
<input type="checkbox"/> Sassouni Plus	<input type="checkbox"/> Farrar <input type="checkbox"/> Gelb <input type="checkbox"/> Gerber	
<input type="checkbox"/> Gerety <input type="checkbox"/> USDI <input type="checkbox"/> Contemp	<input type="checkbox"/> Hard Nightguard <input type="checkbox"/> Levandoski	
<input type="checkbox"/> Gerber <input type="checkbox"/> Functional	<input type="checkbox"/> Myotronic <input type="checkbox"/> Pivotal <input type="checkbox"/> PowerBite <input type="checkbox"/> Sved	
<input type="checkbox"/> Steiner <input type="checkbox"/> Bjork	<input type="checkbox"/> Proform <input type="checkbox"/> Pull Forward <input type="checkbox"/> Stack Pull Forward	
<input type="checkbox"/> Sim <input type="checkbox"/> Mahony		
<input type="checkbox"/> Rondeau <input type="checkbox"/> Other _____	SNORING/SLEEP APNEA	<input type="checkbox"/> EMA <input type="checkbox"/> OASYS
<input type="checkbox"/> Jefferson	<input type="checkbox"/> NAPA <input type="checkbox"/> SILENCER <input type="checkbox"/> SNOAR <input type="checkbox"/> TAP I <input type="checkbox"/> TAP III	

COLORS - Please write colored acrylic preference in SPECIAL INSTRUCTIONS or circle one of the standard designs below.
DESIGNS - Rainbow Tiger Stripe Zebra Stripe Camouflage Lady Bug Watermelon US Flag Smiley Face
 (Some lower arches and fixed appliances may not accommodate custom designs and may need to be simplified.)

LAB USE:

Please do not count Saturdays, Sundays, holidays or days in transit as production days.

Change of Address 2nd Office

DATE SENT: ____/____/____ **DATE WANTED:** ____/____/____ **TIME:** ____:____

DATE WANTED should be at least one day prior to appointment date.

DR. NAME: Last Name _____ First Name _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PATIENT NAME: Last Name _____ First Name _____
 PLEASE PRINT CLEARLY

Male Female **AGE:** _____ I'm a new customer

Please contact me on this case () _____

FIXED ORTHO APPLIANCES

ARCH DEVELOPMENT	A-P CORRECTION	BRACKETING
<input type="checkbox"/> CD Distalizer <input type="checkbox"/> U <input type="checkbox"/> L	<input type="checkbox"/> Fixed Twin Block	<input type="checkbox"/> Controlled Arch <input type="checkbox"/> U <input type="checkbox"/> L
Unilateral <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Banded Herbst <input type="checkbox"/> Bonded Herbst	<input type="checkbox"/> Bands <input type="checkbox"/> U <input type="checkbox"/> L
<input type="checkbox"/> CD Advancer	<input type="checkbox"/> Inclined Bite Plane*	<input type="checkbox"/> Brackets only <input type="checkbox"/> U <input type="checkbox"/> L
<input type="checkbox"/> Expander* (circle one)	<input type="checkbox"/> MARA <input type="checkbox"/> with RPE screw	<input type="checkbox"/> Brackets in Matrix <input type="checkbox"/> U <input type="checkbox"/> L
Fixed <input type="checkbox"/> Wilson* <input type="checkbox"/> FLEA	<input type="checkbox"/> Tandem (Class III)	<input type="checkbox"/> Flat Bite Plane
<input type="checkbox"/> Hyrax RPE (circle one)	<input type="checkbox"/> Reverse Facemask Appliance	_____
2-Band 4-Band Bonded Wire Frame Only		Indirect Bracket Type
<input type="checkbox"/> Haas RPE (circle one)		<input type="checkbox"/> Standard Bracket
2-Band 4-Band Bonded Wire Frame Only	RETENTION / ANCHORAGE	<input type="checkbox"/> Delta Force
<input type="checkbox"/> Controlled Arch <input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/> EZ Bond Retainer <input type="checkbox"/> U <input type="checkbox"/> L	<input type="checkbox"/> Viazis Bracket
<input type="checkbox"/> Molar Distalizing Arch	<input type="checkbox"/> Indirect Lingual Retainer	
<input type="checkbox"/> Multi Action Palatal/Porter*	2-pad multi-pad bond-a-splint (circle one)	
<input type="checkbox"/> NPE Nitanium Palatal Expander	<input type="checkbox"/> U <input type="checkbox"/> L	
<input type="checkbox"/> Quad Action Mandibular*	<input type="checkbox"/> Lingual Arch* <input type="checkbox"/> Nance	
<input type="checkbox"/> Quad Helix*	<input type="checkbox"/> Palatal Arch*	
	<input type="checkbox"/> Band & Loop/Space Maintainer	

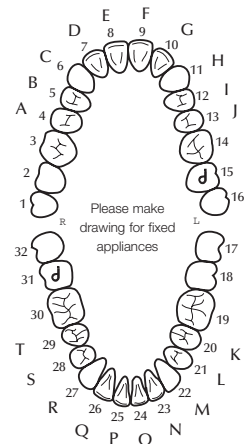
*Indicate how banded appliances are to be attached: (Also indicate midline screw or special design changes where necessary.)
 Soldered Vertical Wilson 3D® Horizontal Mershon Tubes

SPECIAL INSTRUCTIONS

Please note any additional enclosures other than models and bite.

Please specify preferred lecturer design.

R ← Midline → L
 Please Draw in Screw(s) or Special Cuts



- Accounts are due and payable upon receipt of monthly statement. All amounts not paid by the 23rd day of the month following the statement date are subject to a service charge on the unpaid balance at the rate of 2% per month. (24% per annum)
- Accounts not paid within these credit terms will be subject to C.O.D. status.
- Client pays, in full, the stated price of the goods, plus any service charges, plus all costs of collection including attorneys' fees, court costs & other reasonable expenses.

DR'S SIGNATURE: _____ **LICENSE NO.** _____
 REQUIRED BY LAW



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All models and appliances should be returned for remakes, repairs or credit evaluations.