

**Removable Functional Rx**

Dr. \_\_\_\_\_ Acct # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Patient \_\_\_\_\_  
 Tel # \_\_\_\_\_ Fax # \_\_\_\_\_  
 E-Mail \_\_\_\_\_  
 Shipped \_\_\_\_\_ Placement Date \_\_\_\_\_

(PLACEMENT DATE SHOULD BE 1-2 DAYS BEFORE ACTUAL INSERTION DATE)

**Please Ship Extra**

Pre-Paid Bags  Shipping Boxes  Prescription Sheets

**Submitted scans digitally through:**

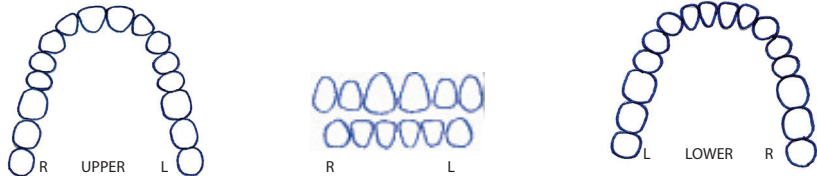
Lythos  iTero  3M  Box  Other \_\_\_\_\_

**(Submit digital Rx to: [digital.services@aolab.com](mailto:digital.services@aolab.com))**

**Special Instructions**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Instructional Drawing**



APPLIANCE PROTECTION PLAN:  
 YES  
 NO

**Allesee Orthodontic Appliances - 13931 Spring Street - Sturtevant, WI 53177**  
**Phone 1-800-262-5221 - Fax 262-886-6879 - International 262-886-1050**

**1. Choose Appliance and Options**

<p><b>Bionator</b></p> <p><input type="checkbox"/> To Open  <input type="checkbox"/> To Close  <input type="checkbox"/> To Maintain  <input type="checkbox"/> Sondhi Modification</p> <p><b>Midline Screw</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Frankel</b></p> <p><input type="checkbox"/> FR I <input type="checkbox"/> FR II <input type="checkbox"/> FR III <input type="checkbox"/> FR IV</p> <p><input type="checkbox"/> Alternate Relief Rt _____ Lt _____</p> <p><input type="checkbox"/> Standard Model Prep. <input type="checkbox"/> Do Not Prep Models  <input type="checkbox"/> Lower Molar Rests <input type="checkbox"/> Advancement Screws  <input type="checkbox"/> Disc Teeth Distal c's and Distal e's</p> <p><b>Sagittal Plate</b> Upper Lower</p> <p>Standard <input type="checkbox"/> <input type="checkbox"/></p> <p>3-Way</p> <p>One Screw <input type="checkbox"/></p> <p>Three Screws <input type="checkbox"/> <input type="checkbox"/> (1 midline + 2 anterior / 1 Midline + 2 posterior (circle one))</p> <p>Class III <input type="checkbox"/></p> <p><b>Occlusal Coverage</b></p> <p>Upper <input type="checkbox"/> Yes <input type="checkbox"/> No  Lower <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Molar Distalizers</b></p> <p><input type="checkbox"/> ACCO <input type="checkbox"/> Shamey</p> <p><b>Twin Block</b></p> <p><input type="checkbox"/> Standard - Upper Midline Screw  <input type="checkbox"/> Lower McNamara design  <input type="checkbox"/> McNamara design  <input type="checkbox"/> Add lower exp screw  <input type="checkbox"/> Standard Type II - Upper and Lower midline screw  <input type="checkbox"/> Omit Midline Screw(s)</p> <p><b>Jackson Expander</b></p> <p><input type="checkbox"/> Upper <input type="checkbox"/> Lower</p>	<p><b>Orthopedic Corrector</b></p> <p><input type="checkbox"/> To Open  <input type="checkbox"/> To Close  <input type="checkbox"/> To Maintain</p> <p><b>Midline Screw</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Schwarz Plate</b></p> <p><input type="checkbox"/> Upper <input type="checkbox"/> Fan screw  <input type="checkbox"/> Nord Design  <input type="checkbox"/> Lower</p> <p><b>Occlusal Coverage</b></p> <p>Upper <input type="checkbox"/> Yes <input type="checkbox"/> No  Lower <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Activators</b></p> <p><input type="checkbox"/> LSU  <input type="checkbox"/> Hamilton Expansion Activator  <input type="checkbox"/> Stockli-Teuscher  <input type="checkbox"/> Torquing Spring <input type="checkbox"/> Labial Bow  <input type="checkbox"/> Woodside Open Face  Headgear Tubes <input type="checkbox"/> .045 <input type="checkbox"/> .051</p> <p><b>Intrusion Appliances</b></p> <p><input type="checkbox"/> Woodside Spring Intrusion Splint</p>
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**2. Misc.**

<p><input type="checkbox"/> <b>Wax Construction Bite Provided</b></p> <p><input type="checkbox"/> Use as is  <input type="checkbox"/> Lab may modify if needed</p> <p><b>Acrylic</b></p> <p><input type="checkbox"/> Pink Tint <input type="checkbox"/> Adams <input type="checkbox"/> Arrow  <input type="checkbox"/> Clear <input type="checkbox"/> Ball <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Color(s) _____  <input type="checkbox"/> Designer Series _____</p>	<p><b>Labial Bow</b> <b>Headgear Tubes</b></p> <p><input type="checkbox"/> Standard <input type="checkbox"/> .045  <input type="checkbox"/> Buccinator <input type="checkbox"/> .051</p> <p><b>Wax Relief</b></p> <p><input type="checkbox"/> Lower Anterior Lingual  <input type="checkbox"/> Lower Posterior Lingual  <input type="checkbox"/> Lower Occlusal  <input type="checkbox"/> Upper Anterior  <input type="checkbox"/> Glitter(s) _____</p> <p><input type="checkbox"/> Carve Brackets/Bands <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Doctor Signature \_\_\_\_\_



**Laboratory Use Only**

MA \_\_\_\_\_

MAC \_\_\_\_\_

FR \_\_\_\_\_

ACT \_\_\_\_\_

BIO \_\_\_\_\_

SAS \_\_\_\_\_

SAT \_\_\_\_\_

AVC \_\_\_\_\_

TB \_\_\_\_\_

AAC \_\_\_\_\_

AAC \_\_\_\_\_

AAC \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SHIP \_\_\_\_\_