INDIRECT BONDING WORLD, LLC
Orthodontic Laboratory

8358 W Oakland Park Blvd, Suite 103, Sunrise, FL 33351
954-533-9143 Fax 754-551-6341 - 888-678-8573
jh@indirectbonding.net - www.indirectbonding.net

INDIRECT BONDING PRESCRIPTION

Date Shipped: _____

Date Required: _____

Dr. ..... ***License #*** .....

Address: .....

City/State: .....Zip Code: .....

Phone: ..... Fax: ..... Email: .....

Doctor's Signature: .....

Patient Name: _____

CASE INFORMATION

_____Upper Arch
_____Lower Arch
_____Brackets enclosed
_____IBW to provide brackets
*Type of brackets*_____
_____Labial Bracket Placement
_____Lingual Bracket Placement

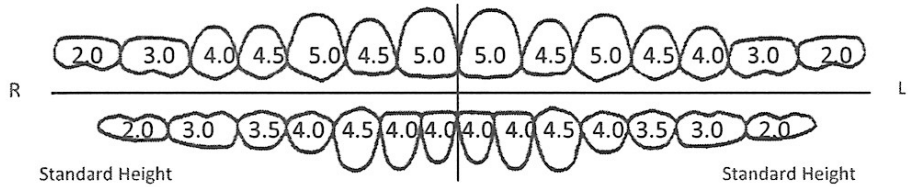
TRANSFER TRAYS

(Please specify cut desired)

_____Full Arch
_____Midline Split
_____Three Sections

NOTE: Please include a copy of the Patient's Panoramic X-Ray with the case. We will return it if requested. Thank you

Please specify on the diagram teeth that are missing, need to be extracted, or not to be bonded, as well as custom height of the brackets and over rotation desired.



SPECIAL INSTRUCTIONS:

_____
_____
_____
_____
_____

PLEASE REMEMBER TO ENTER THE DATE REQUIRED