

Patient: \_\_\_\_\_

Dentist: \_\_\_\_\_

Practice/Address: \_\_\_\_\_

License #: \_\_\_\_\_

<p><b>PROTRUSIVE BITE</b></p> <input type="checkbox"/> Bite represents patient's maximum protrusion (100%) <input type="checkbox"/> Bite represents patient's starting point		<p><b>VERTICAL DIMENSION</b></p> <input type="checkbox"/> Close as much as possible <input type="checkbox"/> Keep it, call if changes needed
<p><b>ELASTICS REQUIRED</b></p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p><b>LATERAL DEVIATION</b></p> <input type="checkbox"/> None <input type="checkbox"/> Yes	<p><b>BRUXISM</b></p> <input type="checkbox"/> None <input type="checkbox"/> Light-Moderate <input type="checkbox"/> Severe

**CHECK TO USE OPTIMAL VALUES** (if checked, do not fill-in the Customize Section)

**CUSTOMIZE SECTION** (check one per Upper and Lower)

<b>UPPER BAND</b>	<input type="checkbox"/> SIMPLE BUCCAL  <b>RECOMMENDED</b>	<input type="checkbox"/> FULL 	<input type="checkbox"/> 1/2 	<input type="checkbox"/> SIMPLE LINGUAL 
	<input type="checkbox"/> 1/2  <b>RECOMMENDED</b>	<input type="checkbox"/> FULL 	<input type="checkbox"/> SIMPLE BUCCAL 	<input type="checkbox"/> SIMPLE LINGUAL 
<b>LOWER BAND</b>	<input type="checkbox"/> STANDARD  <b>RECOMMENDED</b>	<input type="checkbox"/> FULL 	<input type="checkbox"/> ANTERIOR 	<input type="checkbox"/> Central only <input type="checkbox"/> Lateral to lateral <input type="checkbox"/> Canine to canine

**Other factors or specific requests to be taken into account**

(e.g., brittle tooth, mobility, broken tooth, crown, bridge, other)

\_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

\_\_\_\_\_