SIMPLICITY BONDING PRESCRIPTION

800-854-2896

Lancer Orthodontics Inc
1778 East Carr Rd • Suite 3B
Calexico, CA 92231

DOCTOR: ____________________

Address: ____________________

City/State/Zip: ____________________

Tel: ____________________ **Fax:** ____________________

Email: ____________________

PATIENT: ____________________

Date Shipped: ____________________ *Date Required:* ____________________

Appointment Date : ____________________

❑ **Call Me Direct regarding this case** ❑ **Special Instructions on file**

Send Additional: ❑ **Mailing Labels** ❑ **Boxes**

BRACKET PRESCRIPTION INFORMATION (*Please Indicate with a ✓*)

- ***BRACKETS***

  METAL ❑ PRAXIS ROTH **CERAMIC** ❑ INTRIGUE ROTH

- ***UPPER BITE PLANE***

  ANTERIOR BITE PLANE ❑ YES ❑ NO

- ***LINGUAL ARCH***

  Desired additional width at 1st Bicuspid and 1st Molar

  Upper 1st Bicuspid________**mm** **Lower 1st Bicuspid**________**mm**

  Upper 1st Molar________**mm** **Lower 1st Molar**________**mm**

- ***TRAYS*** ❑ Full Arch ❑ Midline Split ❑ 3-Piece

SPECIAL INSTRUCTIONS: *(Use reverse side for further explanations and details.)*

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