



800-854-2896

Lancer Orthodontics Inc
1778 East Carr Rd • Suite 4B
Calexico, CA 92231

Indirect Bonding Prescription

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

← **Case Details** (Please **INDICATE** on Diagram on left)

1. Mark "X" on Teeth... Missing, to be Extracted, or those that will **Not** be Bonded.
2. Please indicate with arrows the **Over-Rotations** desired.

BRACKET PRESCRIPTION INFORMATION (Please Indicate with a ✓)

• **SIZE** (Select One) .018 .022

• **BRACKETS**

METAL PRAXIS ROTH PRAXIS MBT **CERAMIC** INTRIGUE ROTH

• **HOOKS** ALL HOOKS CUSPID HOOKS NO HOOKS REQUIRED

• **BONDING** 5x5 6x6 7x7

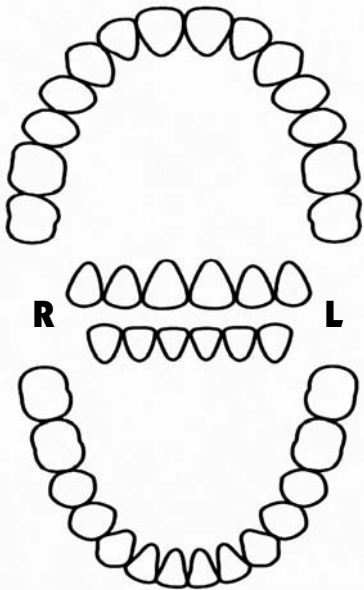
FIRST MOLAR BUCCAL TUBES

- Non-Convertible Single
- Convertble Single
- Other

SECOND MOLAR BUCCAL TUBES

- Non-Convertible Single
- Convertble Single
- Other

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



Bracket Height and Angulation Prescription

• Please mark on the chart below, (with an "X") teeth that have wear, and how much wear exists on each tooth.

Custom Height												
Standard Height	3.0 mm	4.0 mm	4.5 mm	5.0 mm	4.5 mm	5.0 mm	5.0 mm	4.5mm	5.0mm	4.5mm	4.0mm	3.0mm
Requested Angulations												
Requested Angulations	R L											
Requested Angulations												
Standard Height	3.0 mm	3.5 mm	4.0 mm	4.5 mm	4.0 mm	4.0 mm	4.0 mm	4.0mm	4.5mm	4.0mm	3.5mm	3.0mm
Custom Height												

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