WAX-UPS

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VANCOUVER, BC, V5T 1A7
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In office use only: T:_____

DATE:_____ DR'S PHONE:(____)_____

DR._____

PATIENT NAME:_____

☐ MALE ☐ FEMALE

RETURN DATE:_____RETURN TIME: _____AM/PM

Rx:_____

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Dentist is Providing:

☐ Pre-Op Model ☐ Mock-Up Model ☐ Bite Index ☐ Stickbite
☐ FaceBow ☐ Photo(s) ☐ Other_____

Please indicate alteration(s) from original:

Horizontal Plane - please follow :

☐ Study Model ☐ Stick-Bite ☐ Photo(s) ☐ Mock-Up
☐ Other_____

Overbite (Length) – please follow:

☐ Study Model ☐ Mock-up ☐ Photo
☐ Measurements _____
☐ Other_____

Over Jet – please follow:

☐ Study Model ☐ Mock-Up ` ☐ Photo
☐ Measurements_____
☐ Other_____

Other Alterations:_____

_____

_____

Please indicate any prosthetic tools that the dentist requires:

☐ Trial Prep Model ☐ Putty Index ☐ Putty Reduction Stent(s)
☐ Other_____

DOCTOR'S SIGNATURE:_____