

PLEASE DO NOT COUNT SATURDAYS, SUNDAYS, HOLIDAYS, OR DAYS IN TRANSIT AS WORK DAYS

DATE NEEDED: _____
TIME: _____

IMPLANT SOLUTIONS USE ONLY
PAN # _____

PATIENT NAME: _____
MALE FEMALE AGE: _____
DOCTOR: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

IMPLANT SOLUTIONS USE ONLY
CALLED DOCTOR: _____
(INITIAL)

PRINT PATIENT NAME

FABRICATE SCANNING APPLIANCE FABRICATE SURGICAL STENT AFTER CT SCAN IS COMPLETED

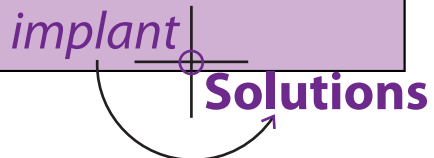
IMPLANT MANUFACTURER, DIAMETER, LENGTH:

TYPE OF RESTORATION: _____ TOOTH NUMBER: _____
UPPER LOWER

INSTRUCTIONS:

Please return the appliance and disk to Implant Solutions

SIGNATURE: _____
LICENSE NO: _____



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