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Case No.

PAN #

T

Doctor _____ Date _____

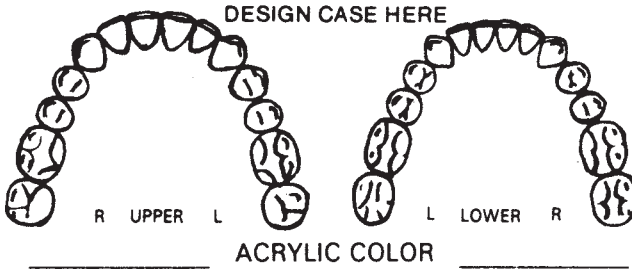
Address _____

City _____ State _____ Zip _____

DUE DATE _____ Chair Time _____ A.M. _____ P.M. _____

PATIENTS NAME

First Name _____ Middle _____ Last Name _____



NOTES:

SPACE MAINTAINERS

Nance Button ☐ Lingual Arch ☐ Unilateral ☐

Distal Shoe ☐ Band Tooth # _____ Replace Tooth # _____

All appliances are warranted for **60 days** from date manufactured.

Office will be responsible for accuracy of working cast.

Please send white & yellow copies to laboratory, retain pink copy for file.