OrthoProLiners by
ORTHO PRO
DENTAL APPLIANCES INC.

PLEASE SEND
- ☐ Prescriptions
- ☐ Shipping bags
- ☐ Waybills

☐ Proceed as indicated ☐ Consult client with treatment plan/cost

OrthoProLiner TOOTH ALIGNMENT PRESCRIPTION

DOCTOR _____

ADDRESS _____

CITY _____ PROVINCE _____

POSTAL CODE _____ PHONE NO. _____

PATIENT _____ AGE _____

DATE _____ DATE DUE _____

ALIGNMENT TREATMENT

Maxilla ☐ Please reset ⑤④③②① | ①②③④⑤

Mandible ☐ Please reset ⑤④③②① | ①②③④⑤

Align to Ideal ☐

Indicate teeth which are sensitive or should not be moved.

⑤④③②① | ①②③④⑤

⑤④③②① | ①②③④⑤

ATTACHMENTS

☐ Place attachments as needed ⑤④③②① | ①②③④⑤

☐ Place attachments on ⑤④③②① | ①②③④⑤

☐ No Attachments

INTERPROXIMAL REDUCTION (IR)

☐ If needed use IR and inform ⑤④③②① | ①②③④⑤

☐ Please use IR as indicated ⑤④③②① | ①②③④⑤

☐ Do not use IR

SPECIAL INSTRUCTIONS _____

DOCTOR'S SIGNATURE _____

#3 2727 Quadra Street
Victoria, BC V8T 4E5

Ph: 250-370-7070
Fax: 250-370-7072

Toll Free: 1-800-563-3334
Email: orthopro@telus.net