



INTERNATIONAL DENTAL ORTHOTIC LLC

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Doctor Name: _____

License: _____

Address: _____

Phone: _____

Business E-mail: _____

✓ Preferred: Phone E-Mail

Patient/Client: _____ DOB: _____

Vertical Index Measurements Required:

@ C.O. Right Posterior _____ mm # ___/___ Anterior _____ mm # ___/___ Left Posterior _____ mm # ___/___

@ Myocentric Right Posterior _____ mm # ___/___ Anterior _____ mm # ___/___ Left Posterior _____ mm # ___/___

Lab Contact Marks Visible Removed

Comments/Instructions: Call Dr. Phone: _____

Due Date: Request orthotic to arrive _____

Our business cards are enclosed for complimentary IDO luggage tags

We need shipping supplies. Please circle Rx Forms Boxes Labels

Signed: _____

Please visit us at www.dentalorthotic.com

INDICATE PRODUCT REQUESTED

- Removable orthotic & extra stent
- Removable orthotic, extra stent & diagnostic study model
- LVI orthotic, wax-up with matrix area
- LVI orthotic & diagnostic study model
- Diagnostic study model
- IDO consultation orthotic demonstrator