SOL
Simply Ortho Lab

Address: PO Box 401
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ABN: 52 356 841 633

Dentist: DATE / TIME DUE:
Address:
Phone:

INDIRECT BONDING LAB SHEET

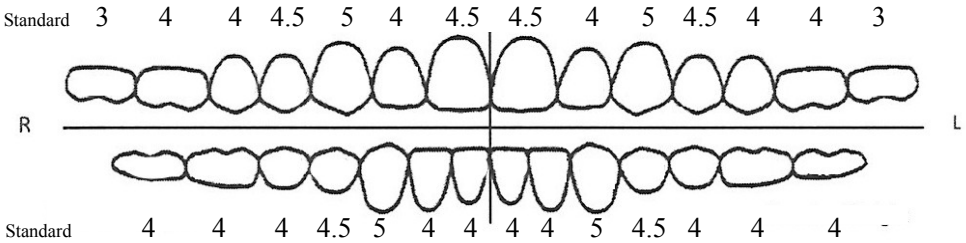
PATIENT NAME: _____

Circle: Upper Lower

Circle: Custom Pads (Transbond XT) YES NO

Circle: Full Arch Midline Split Three Sections

Please indicate custom height if required. If no height indicated, brackets will be placed at Standard heights as shown.



SPECIAL INSTRUCTIONS: _____
_____
_____
_____

PRIOR TO PACKING: Please ensure brackets are enclosed, models or impressions are carefully wrapped and lab sheet is completed including due date

Dentist Signature_____

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