



OrthoProof Australasia Pty Ltd

Suite 3, 875 Glenhuntly Road, Caulfield South, Victoria 3162
Phone (03) 9519 9100 Fax (03) 9519 9111

Digital Model Order Form

	Deliver To (if different)
Dr Name: _____	_____
Address: _____	_____
_____	_____
_____	Required By (if Urgent)
Date: _____	_____
Patient ID: _____	
Last Name: _____	
First Name: _____	
Date of Birth: _____	

Please tick the appropriate box

Enclosed:		Occlusal Relationship:			
Upper	<input type="checkbox"/>	Class 1	<input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Lower	<input type="checkbox"/>	Anterior Open Bite	<input type="checkbox"/>		
Bite	<input type="checkbox"/>	Cross Bite	L <input type="checkbox"/>	R <input type="checkbox"/>	Both <input type="checkbox"/>
	CO <input type="checkbox"/>	CR	<input type="checkbox"/>		
Photos	<input type="checkbox"/>	Comment:	_____		

Material Used:

Alginate	<input type="checkbox"/>	Pre Treatment	<input type="checkbox"/>
PVS	<input type="checkbox"/>	Mid treatment	<input type="checkbox"/>
Plaster	<input type="checkbox"/>	Post Treatment	<input type="checkbox"/>
		Trial Wax Up	<input type="checkbox"/>

We require all of the above information to ensure that we provide you with the highest standard of quality and accuracy