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 Toll Free (800) 228-6663 Visit our customer hub
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Customer Hub

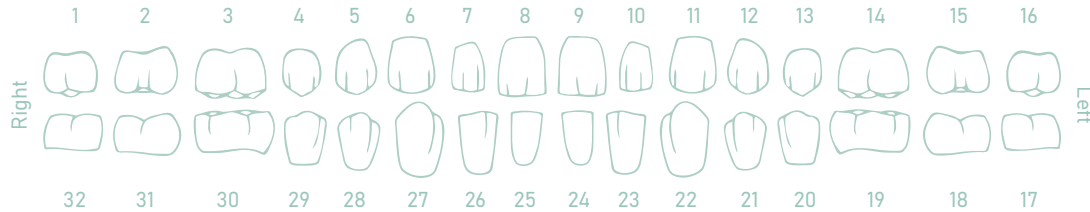
Please ✓ applicable boxes. Required fields indicated with asterisk (*).

TREATMENT

Align the treatment from* 3-3 (anterior only) 5-5 (2nd premolar to 2nd premolar) 7-7 (includes molars)
 Esthetic Treatment* (see below) Both Upper Lower
 Allow IPR* Yes No Exclude teeth (mark below)
 Allow Attachments* Yes No Exclude teeth (mark below)

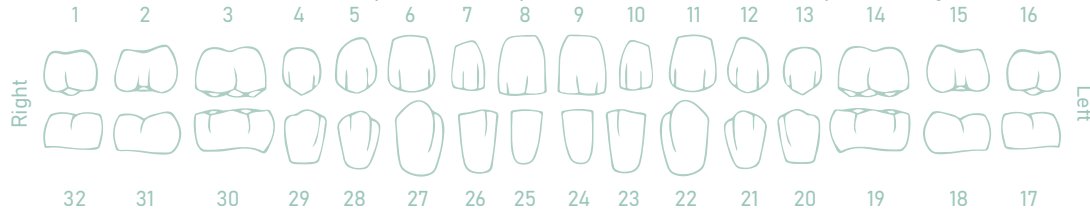
Please indicate which teeth you would like to exclude from IPR or attachments with the following code:

EI - Exclude from IPR EA - Exclude from Attachments



Please indicate all teeth with restorations and/or implant sites with the following code:

R - Restoration (non-implant) I - Implant Restoration Site SB - Splinted Bridge



MIDLINE (mark only if needed)

Midline Upper Improve Maintain
 Move Upper To patient left To patient right
 .5mm 1mm 2mm
 Midline Lower Improve Maintain
 Move Lower To patient left To patient right
 .5mm 1mm 2mm

TOOTH SIZE DISCREPANCY

IPR in Opposite Arch (dual arch only)
 Leave Spaces Open Distal to
 Laterals Canines

OVERJET OVERBITE

Maintain Maintain
 Improve Improve

ANTERIOR POSTERIOR RELATION

Maintain Upper Lower
 Improve Canine Relationship Only Left Right
 Leveling of Anterior Teeth Incisal edge Gingival margin

Doctor Name* _____ Date _____

Address* _____

City* _____ State* _____ ZIP* _____

Patient Name* _____ Age* _____ Male Female

RETURN BY 5:00 P.M. ON _____ Phone* _____

Email* _____

Expedite - same day and expedite requests will be honored, additional fees apply.

CALL ME

DO YOU NEED?

Rx Days in Lab
 Boxes Shipping Labels

Instructions

Please indicate Dr. & patient goals*

Signature* _____ License #* _____

The person signing this work order accepts responsibility for payment and agrees to pay all collection costs including attorney's fees. A 1.5% (18%/yr.) finance charge will be added to all balances due over 30 days.

For the most up-to-date Rx & forms, please visit www.roedentallab.com/forms