

Kuper Orthodontics, Inc.

24706 75th STREET • SALEM, WI 53168-0087

TOLL FREE # 800-272-2926 • FAX 262-843-3871

APPLIANCE REQUISITION

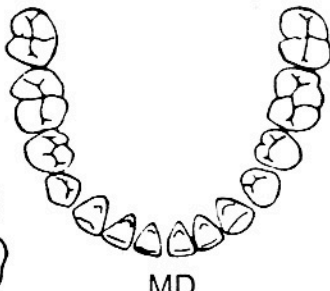
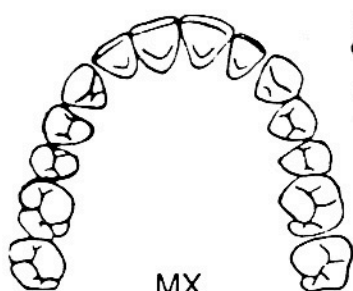
Doctor _____ Address _____

City & State _____ Zip Code _____

Patient's Name _____

PLEASE PRINT OR TYPE CLEARLY

For Lab Use



Date Wanted

INSERT PATIENT'S NAME IN APPLIANCE SEND RETAINER CASE

INSTRUCTIONS

(CONSTRUCT AND DELIVER TO THE UNDERSIGNED ONLY. THE DESCRIBED APPLIANCES)

Doctor Signature _____ Date _____

Dental License Number _____

PLEASE SEND ADDITIONAL:

PRESCRIPTION
FORMS

MAILING
LABELS

SHIPPING
BOXES