orthocaps®

SUBMISSION OF PATIENT RECORDS

Date of dispatch:_____

Doctor:

_____

Name Firstname Telephone

Paziente: Case ID:_____

_____

Name Firstname Date of birth

Please indicate below if the patient records are inclosed or were submitted electronically (online)!

☐ New Case ☐ 2./3.Phase ☐ Refinement

Patient Records	Included in box	Submitted online
1. Upper impression	☐	
2. Lower impression	☐	
3. Bite registration	☐	
4. X-Rays		
Panoramic Radiograph		☐
Cephalometric Radiograph		☐
Intraoral Radiographs		☐
5. Photographs		☐

Notes:_____

_____

_____

IMPRESSIONS AND BITE REGISTRATION HAVE TO BE PROPERLY DISINFECTED!

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