



Orthognathic Digital Plan Order Form

 Include CT data from radiology and a front facing photo per the **Orthognathic Scanning Protocol** on disk or upload to ftp site.

 Ship stone teeth to ProtoMED for scan and model integration

Order Information:

Surgeon Name: _____ Patient Name/ID: _____
 Phone Number: _____ Scan Date: _____
 Secondary Contact Number: _____ Surgical Facility: _____
 Fax Number: _____ Surgery Date: _____
 Email Address: _____
 Address: _____

Physical Parts Ordered:

Bite Splint

- Final
 Intermediate

Anatomical Model

- Epoxy
 Acrylic
 Plaster

Cephalometric Analysis:

Special Instructions: _____

Available Ethnic Norms: African American American Indian Anglo American
 Caucasian Chinese Korean Latin

Surgery Types:

Mandible:

- Sagittal Split: L R
 IVRO: L R
 EVRO: L R

Genioplasty:

- Augmentation: Autogenous Alloplast
 Reduction:
 Correct Asymmetry: Autogenous Alloplast

Maxilla:

- LeFort I:
 Multiple Piece LeFort: Pieces _____
 LeFort II:
 LeFort III:

Temporomandibular Joint:

- Implant: L R

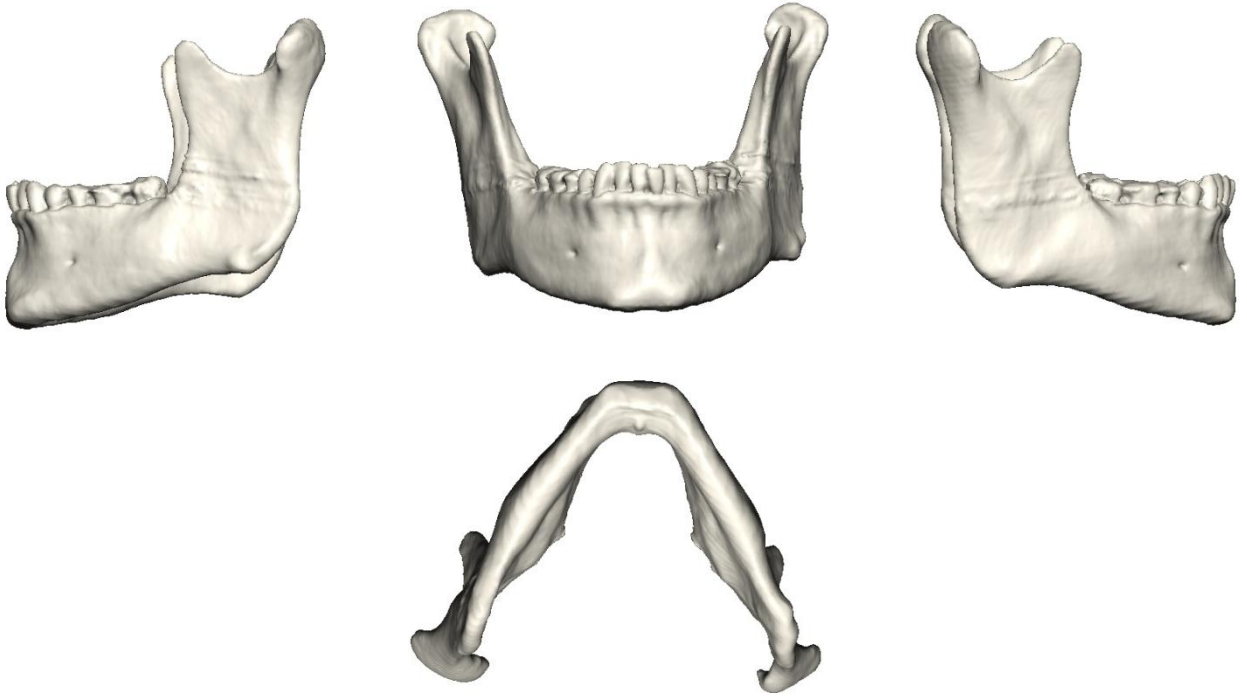
Other:

For questions concerning you order, please contact ProtoMED

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E-mail: info@protomed.net
 Web: www.protomed.net

Sketch Mandibular Cut Positions:



Sketch Maxillary Cut Positions:

