



MidLyneTM
Orthodontic Laboratory

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R Indirect Bonding

Patient's Name _____

Date Wanted _____

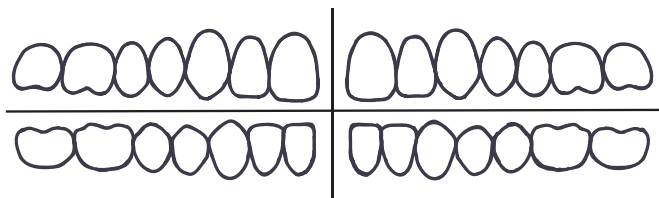
(Please request at least 1 business day prior to patient appt.)

Doctor _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Email _____



Bracket Placement: Please Specify mm From Incisal Edge In Tooth Spaces Above

- | | |
|--|-------------------------------|
| <input type="checkbox"/> Dr. Provided Brackets | <input type="checkbox"/> .018 |
| <input type="checkbox"/> MidLyne TM Provided Brackets | <input type="checkbox"/> .022 |
| (Bracket System Preference) _____ | |

- Tray Selection
- ☐ Full Arch
 - ☐ Midline Section
 - ☐ Triple Tray

- ☐ 3-3 Composite Retainer

Instructions / Comments _____
