Perio Max+ Rx Form

UNIVERSAL LAB , INC.®
11917 Front St. Norwalk, CA 90650
Office: 562. 484. 0500 I Fax: 562. 484. 3633 I uniortholab.com

☐ CONTACT ME REGARDING CASE ☐ ADDRESS CHANGE

Customer Information

Patient Name:
First Name
Last Name

Date of Birth: ____ /____ / _____ Gender: ☐ Male ☐ Female

Account Number: _____

Dr./Office Name: _____

Office Address: _____

_____

_____

Phone: _____ Email: _____

☐ **Normal** ☐ **Rush** (Extra fee will apply)

Date Sent: ____ /____ / _____
For a normal case, please allow 5 to 7 business days.

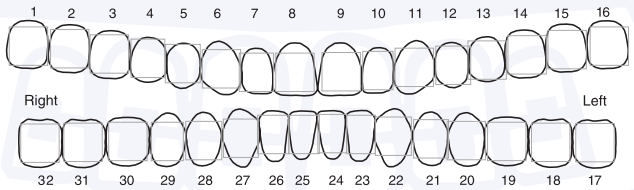
Due Date: ____ /____ / _____
*Should be at least 1 day before appointment date.

Tray Information

☐ New Case ☐ Replacement ☐ Remake
*All new cases include custom 1 tray, 1 cady, 1 gel tube.
*Replacement and remakes do not include a gel tube.

1. **Tray(s) Requested** ☐ Upper ☐ Lower ☐ Set
2. **Pontics & Modifications**
Please note all pontics and indicate any special modifications.
If this case involves extractions, note extraction date, tooth numbers and scheduling.

Digital extraction?
☐ Yes (lab will remove indicated teeth from tray)
☐ No



3. **Enclose the Following**
☐ Impression(s) ☐ Recent Perio Chart

Additional Order

☐ Perio Max+ Oral Cleansing Gel Mint Flavor 3oz/Tube _____ (Qty)

Perio Max Terms & Conditions

- Take a deep impression and capture accurate dentition and approximately 4mm beyong gingival margin.
- Package models carefully and individually to avoid damage.
- When shipping several cases in one box, each case should be separated and clearly labeled.
- Extra fees may apply to repair or rebuild models.

Contact Information

We are here for you **Monday through Friday from 7:00 AM to 3:30 PM**
Please feel free to contact our Customer Service team

1. **Email us at:**
Customerservice@uniortholab.com
2. **Call us at:**
Toll Free: 877-771-3633
3. **Visit our website at:**
uniortholab.com

Upload cases at:
http://labslip.uniortholab.com/

Perio Max+
Professional At-Home Treatment for Healthy Gums

Dr. Notes (Additional Comment)

_____

_____

_____

_____

_____

Authorization

Doctor Name: _____

Doctor Signature:

License Number: _____

LAB USE ONLY

SHIP DATE

QR CODE

RECEIVED DATE