



UNIVERSAL ORTHODONTIC LAB, INC.®

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1002617

LAB USE ONLY

- ☐ CONTACT ME REGARDING CASE ☐ ADDRESS CHANGE
☐ MORE LABSLIPS ☐ NEW ACCOUNT

Practice Name: **SOUTH SHORE ORTHODONTICS** Acct#: **92349**
Ship to: **2655 MERRICK RD.**
City: **BELLMORE** State: **NY** Zip: **11710** Phone: **516-783-1121**
E-Mail: **SOUTHSHORESMILESORTHO@GMAIL.COM**

Patient First Name **Cameron** Last Name **Monteith**

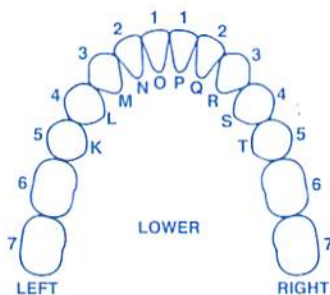
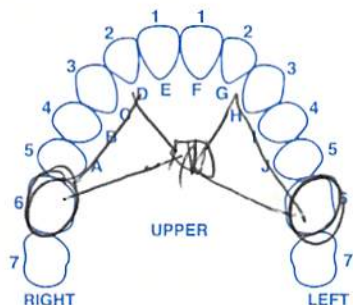
☐ Normal ☐ Rush

Date Sent: _____

Due Date: _____

For a normal case, please allow 7 business days.

*Should be at least 1 day before appointment date.



- ↑ ↓ INSTRUCTIONS:
- | | | |
|---|---|---------------------|
| U | L | Standard Hawley |
| U | L | Ball Clasp |
| U | L | "C" Clasp |
| U | L | Adams Clasp |
| U | L | Circum. Hawley |
| U | L | Hawley w/Flat Bow |
| U | L | Circum. w/Flat Bow |
| U | L | Pouring (add'l fee) |

Dr. Notes (Additional Instruction)

RPE (hyrax)
Thank you.

RMA#: _____ (If Applicable)

LAB USE ONLY

RECEIVED DATE



UL2328070

SHIP DATE

