TRU-LINE™
INVISIBLE ORTHODONTIC SYSTEM

Date Required

_____

By 5:30 pm

Case Number: _____
(if a continuing case)

Dr: _____ Date: _____

Practice: _____

Patient Name: _____

Please Select

TRU-LINE Aligners™

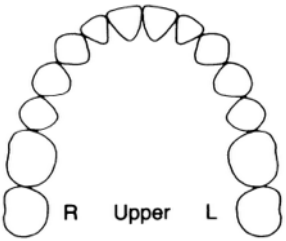
Upper

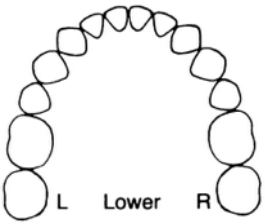
Lower

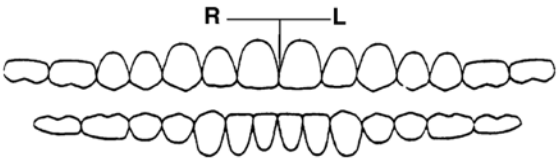
i-expanders™

Upper

Lower







Specific Instructions:

_____

_____

_____

_____

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