Appliance Return Form

PERFECT FINISH
ORTHO LAB

Office Name/Customer ID _____

Doctor Name _____

Patient Name/Case ID _____

Reason for Return _____

_____

_____

Please Mark which items are being returned:

- ☐ Original working model
- ☐ Appliance
- ☐ New impression/scan
- ☐ Other _____

Date of Appliance Fabrication:

_____

Yes	No	
☐	☐	**Is a remake being requested at this time?**
☐	☐	**Are you seeking a credit?**
☐	☐	**Would you like to be notified about the credit decision?**

Contact Name: _____

Phone Number: _____

Email: _____

Please add any additional comments or concerns _____

_____

Name _____

Date of Return _____

Signature _____