TMJ Concepts
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TMJ IMPLANT ORDER FORM

FOR OFFICE USE ONLY

CASE #: ____ **Inf. Consent:** ☐

Contact Date: ____ **Initial:** ____

PHYSICIAN'S OFFICE INFORMATION

Doctor:

Address:

City, State, Zip (Postal) Code:

Country:

Doctor's Email:

Office Phone #:

Office Fax #:

Office Contact:

Contact's Phone #:

Contact's Email:

PATIENT INFORMATION

Last Name:

First Name: **Middle:**

Address Line 1: **Phone #:**

Address Line 2: **DOB (mm/dd/yyyy):**

City, State, Zip (Postal) Code:

Sex: ☐ Male ☐ Female

Country:

Side: ☐ Left ☐ Right ☐ Bilateral

HOSPITAL INFORMATION

Hospital Name:

OR Purchasing Contact: **Phone #:**

Email: **Fax #:**

Purchase Order Number:

CASE INFORMATION

Surgery Date: ____ ☐ Proposed ☐ Scheduled ☐ TBD

Case Description: ☐ Single Stage **OR** ☐ Staged Procedure (2-Stage) 1st Stage Sx Date: ____

Scan Date: ____

Model Build Instructions:

☐ 1-Piece Model (Good Occlusion)

☐ 2-Piece Model (Poor Occlusion)

☐ Unsure

☐ No Planning Required

☐ Virtual Planning

Vendor: ____

Virtual Model Preparation:

☐ Stone Model Integration (Occlusion Set)

☐ Resection(s)

☐ Cutting Guide(s)

Orthognathic Planning:

☐ None

☐ LeFort

☐ Contralateral SSO

NOTES: