Date: _____

Orthognathic Scanning Form

Surgeon _____ Pratice or Hospital _____

Return Address _____

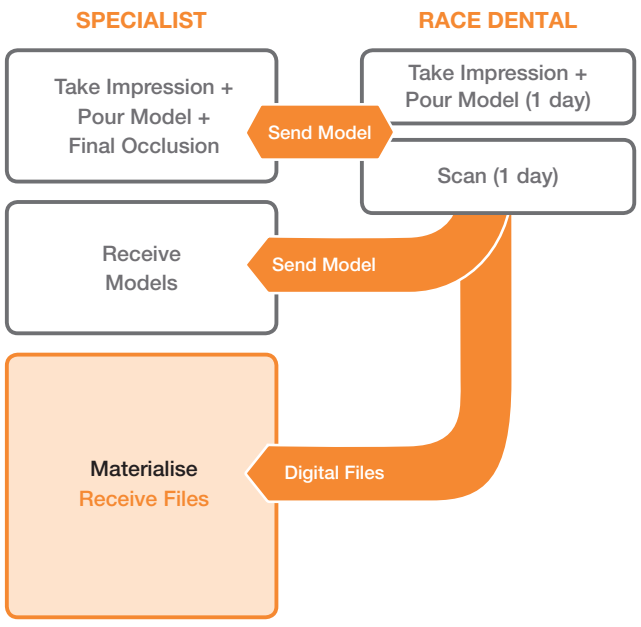
Email _____ Phone _____

Materialise Contact _____ Patient _____

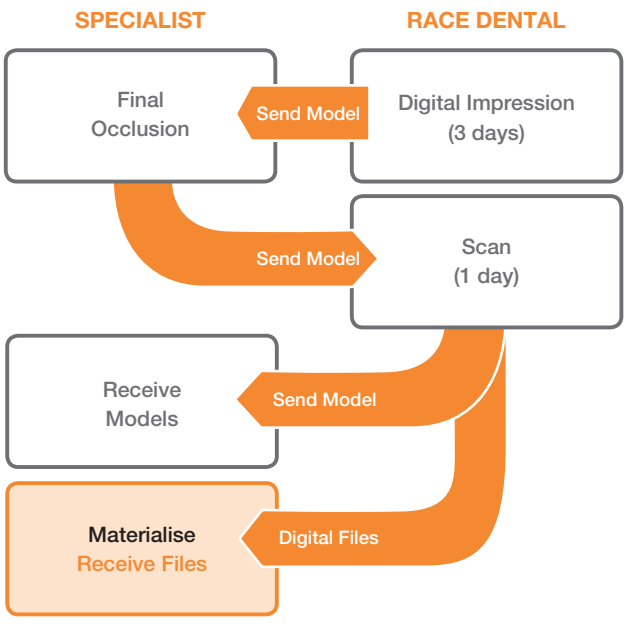
OBL Case ID (eg ME14.XXX.XXX) _____ Return Date _____

SELECT OPTION:

☐ **OPTION 1:** TRADITIONAL



☐ **OPTION 2:** DIGITAL



COMMENTS

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