

From: _____

Lab Use Only	
Pan	Date
Plaster	Wax
Porcelain	Polish
QC	

Date: _____

Deliver by 5pm on: _____

Please refer to our time schedule. If no date is indicated we will automatically assume standard working time.

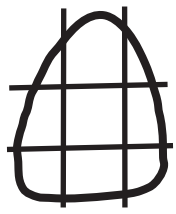
(Please Print)

Patient: Last _____ First _____

Shade: _____ Age: _____ Male Female

Occlusion <input type="checkbox"/> Out <input type="checkbox"/> Light <input type="checkbox"/> Contact	Occlusal Stain <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Dark	Embrassure <input type="checkbox"/> Open <input type="checkbox"/> Natural <input type="checkbox"/> Close	If No Occlusal Clearance <input type="checkbox"/> Metal Lingual <input type="checkbox"/> Metal Occlusion <input type="checkbox"/> Reduction Coping <input type="checkbox"/> Spot Opposing	Buccal Margin Design <input type="checkbox"/> Metal ____mm on Buccal <input type="checkbox"/> Porcelain Butt Margin
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Custom Shade




Metal Design (Please Circle)

Anterior


Full Metal Lingual 1/4 Metal Lingual



Posterior



Pontic Design



No Contact
 Point Contact
 Modified Ridge
 Full Ridge

- Die Trim
- Metal Try-In
- Biscuit Try-In
- Finish

Specific Instructions

Please Call

Doctor (Please Print)

Signature

License Number