

PLEASE PRINT:

Doctor: _____

Address: _____

Phone #: _____

Fax #: _____

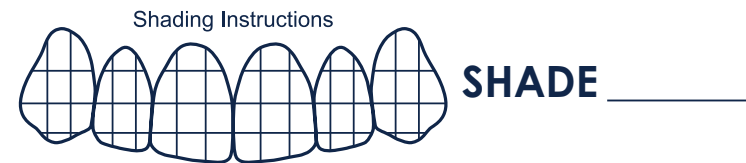
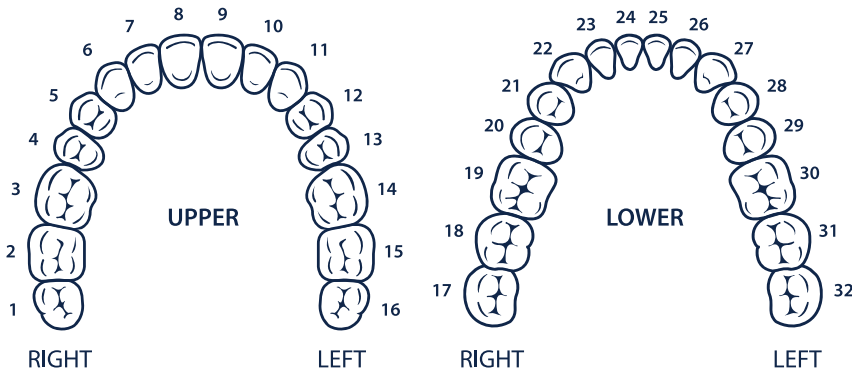
E-mail: _____

Patient: _____

Age: _____ Female ☐ Male ☐

Delivery Date: _____ Next appointment: _____

Please allow 10 days in lab



Dr.'s Signature: _____

License #: _____ Date: _____

Net amount of invoice is due within 30 days of order; all balances beyond 30 days are subject to finance charge of 1.5%. I agree to pay reasonable attorneys fees and collection costs if this account is referred to collection.

FIXED

PFM:

- ☐ High Noble White
- ☐ High Noble Yellow
- ☐ Noble
- ☐ Predominantly Base
- ☐ Captek[®]

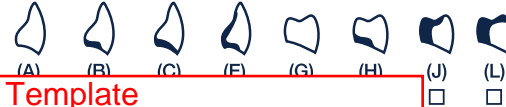
FULL CAST:

- ☐ High Noble Yellow
- ☐ High Noble White
- ☐ Noble
- ☐ Predominantly Base

Ceramics:

- ☐ e.max[®]
- ☐ Full Contour Zirconia
- ☐ PFZ Porcelain Fused to Zirconia

Margin design:



If insufficient occlusal clearance

- ☐ Please Call
- ☐ Reduce/Mark on Opposing

PARTIALS

- ☐ Metal Framework
- ☐ Acrylic
- ☐ Cast Combo
- ☐ Flexible

- ☐ Upper
- ☐ Lower
- ☐ Try-in
- ☐ w/ Set-up
- ☐ w/ Bite Block
- ☐ w/ Finish

GUARDS

- ☐ Hard Night Guard
- ☐ Soft Mouth Guard

Notes: _____

SEND MORE

- ☐ RX's
- ☐ Shipping Labels
- ☐ Boxes

Placeholder Template
Replace with Lab Branded RX Form