

RX Date: _____

Prescribing Doctor: _____

Patient Name: _____

DOB: ____/____/____ Female Male

Today's Date: ____/____/____ Due Date: ____/____/____ by 5pm.

Ship to Address (if different than Prescribing Dr.): _____

City _____ State _____ Zip _____

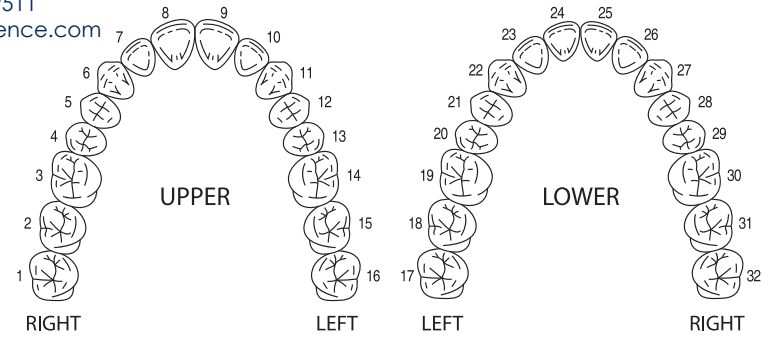
Phone: _____



ADVANCED DENTAL TECHNOLOGIES

5420 Kietzke Ln. Ste. 205 • Reno, NV 89511
P: 775.827.6645 • F: 775.827.6650 • ndxnsequence.com

TEETH	
<input type="checkbox"/> Plastic	<input type="checkbox"/> Porcelain
<input type="checkbox"/> Composite	Mold: _____
SHADE	



MAXILLA	MANDIBLE
<input type="checkbox"/> Reline <input type="checkbox"/> Full <input type="checkbox"/> Repair <input type="checkbox"/> RPD (frame) <input type="checkbox"/> Tooth #'s _____ <input type="checkbox"/> Repair Fracture <input type="checkbox"/> Flexible <input type="checkbox"/> With Reinforcement	<input type="checkbox"/> Reline <input type="checkbox"/> Full <input type="checkbox"/> Repair <input type="checkbox"/> RPD (frame) <input type="checkbox"/> Tooth #'s _____ <input type="checkbox"/> Repair Fracture <input type="checkbox"/> Flexible <input type="checkbox"/> With Reinforcement

Extracting this Appt #'s: _____ Extracting at Delivery #'s: _____ <input type="checkbox"/> Stayplate <input type="checkbox"/> #'s: _____ <input type="checkbox"/> Custom Tray <input type="checkbox"/> holes <input type="checkbox"/> NO holes <input type="checkbox"/> Metal Framework: <input type="checkbox"/> Lab Design (default) <input type="checkbox"/> Doctor Design <input type="checkbox"/> Tooth Colored Clasps <input type="checkbox"/> Shade of Clasp _____ <input type="checkbox"/> Bite Blocks <input type="checkbox"/> Tryin w/ Teeth <input type="checkbox"/> See Special Instructions <input type="checkbox"/> Will be an immediate <input type="checkbox"/> Will be a Flexible partial <input type="checkbox"/> Reset/Remount (will be returned in wax) <input type="checkbox"/> See Special Instructions <input type="checkbox"/> Full Finish <input type="checkbox"/> See Special Instructions <input type="checkbox"/> Custom Gum (Extra Charge) <input type="checkbox"/> Flexible Partial Finish <input type="checkbox"/> Immediate Straight to Finish	Extracting this Appt #'s: _____ Extracting at Delivery #'s: _____ <input type="checkbox"/> Stayplate <input type="checkbox"/> #'s: _____ <input type="checkbox"/> Custom Tray <input type="checkbox"/> holes <input type="checkbox"/> NO holes <input type="checkbox"/> Metal Framework: <input type="checkbox"/> Lab Design (default) <input type="checkbox"/> Doctor Design <input type="checkbox"/> Tooth Colored Clasps <input type="checkbox"/> Shade of Clasp _____ <input type="checkbox"/> Bite Blocks <input type="checkbox"/> Tryin w/ Teeth <input type="checkbox"/> See Special Instructions <input type="checkbox"/> Will be an immediate <input type="checkbox"/> Will be a Flexible partial <input type="checkbox"/> Reset/Remount (will be returned in wax) <input type="checkbox"/> See Special Instructions <input type="checkbox"/> Full Finish <input type="checkbox"/> See Special Instructions <input type="checkbox"/> Custom Gum (Extra Charge) <input type="checkbox"/> Flexible Partial Finish <input type="checkbox"/> Immediate Straight to Finish
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REMOVABLE RX

SPECIAL INSTRUCTIONS	
<input type="checkbox"/> Please call about this case	

Payment Method: *New clients will be billed by credit card unless credit application has been completed

Visa MC AE COD

Card#: _____ Exp: _____

Signature: _____

Print Name: _____

Card will be kept on file for future purchases and will automatically be charged upon case shipment.

Email pictures to: photos@nsequence.com
 Incomplete lab slip will delay your case.

Dr.'s Signature: _____

License #: _____