Doctor:	
Practice:	
Address:	
Phone #:Fax #:	
E-mail:	
Patient First Name:	
Last Name:	
DOB: / / DOB: Male	
Today's Date:/ Return Date:/	
Return Time://	
SHADE Tooth Shade:	
Notes:	ase
Photos sent - ndxtwincitiesphotos@nationale	dentey com
naxiwiricinesprioros@nationale	y 10
5	12
3 (S) UI	PPER 14
ı (Ţ) RIGHT	16 LEFT
32 (3)	17
30 LC 30 29 C	OWER 18
28 27 20 20 20 20 20 20 20 20 20 20 20 20 20	21 22 25 24 23
Dr.'s Signature:	
License #:	
SEND MORE □RXs □Labels □Boxes	



1740 Prior Avenue • Falcon Heights, MN 55113 D. 7/2 70/ 0101 - NDVT- :-- C'#

P: 763.786.9121 • NDX1WINCITIES.COM
DENTURES □ Upper □ Lower
Setup:  □ Ideal □ Balance Occlusion □ Lingualized Occlusion □ Follow Study Model □ Irregular
Acrylic Shade:
□ Original □ Medium □ Light/Medium □ Dark/Medium □ Dark
Stage:  _ Tray  _ Bite Blocks _ Setup _ Reset _ Finish
SPECIALTY Upper Lower
Rem-e-deze™       TAP® 3       NTI-tss Plus™         Thermo-Guard       EMA® Snoreguard       Retainer         Hard Nightguard       ClearDream®       .040         Comfort H/S       Bleaching Trays       .060         Diamond Dream       Mouth Guard       .080
PARTIALS Upper Lower
TC   Flex Shade
Stage:

 $\square$  Frame only  $\square$  w/ Bite Block  $\square$  w/ Setup  $\square$  w/ Finish

Teeth: ☐ Economy ☐ Premium

FOR LAB USE ONLY

Net amount of invoice is due within 30 days of order; all balances beyond 30 days are subject to a finance charge of 1.5%.