



Dr. _____ Phone _____
PRINT

Dr. Office / City _____ Account # _____

Patient _____ / _____ Chart # _____ ☐ F ☐ M
PRINT LAST NAME PRINT FIRST NAME

DUE DATE ____ / ____ / ____ **SHADE** _____

IMPLANTS ☐ Custom Titanium Abutment
☐ Screw Retained
☐ Cementable

☐ Zirconia Full Contour
☐ Zirconia Multi Layered Full Contour
☐ Zirconia Cutback / Porcelain Overlay
☐ Emax
☐ Veneers ☐ Inlay / Onlay

PFM ☐ Non-Precious ☐ Semi* ☐ HN White Gold*

FMC ☐ Non-Precious ☐ Semi Yellow Tint*

☐ HN Yellow Gold*

*Plus cost of Alloy Weight

STUMP SHADE

☐ Enclosed with case ☐ Impression ☐ Models
☐ Bite ☐ Photo ☐ Partial ☐ Others _____

REMOVABLE ☐ UPPER ☐ LOWER

☐ Full Denture
☐ Partial Denture w/Metal Frame
☐ Valplast Partial
☐ Valplast Combo w/Metal Frame

☐ Stayplate

☐ Nightguard _____

☐ Repair
☐ Reline
☐ Rebase

Ortho Retainer

☐ Clear

☐ Hawley

Rx **Implant System (Must provide):** _____

Platform Size (Must provide): _____



IF NOT ENOUGH CLEARANCE: ☐ Adjust Prep. Plus Reduction Coping ☐ Spot Opp. ☐ Call Dr.

Dr's Signature: _____ Date: _____

TERMS: 3% monthly service charge over 30 days of statement date. Customer agrees to pay full cost of collection plus attorney fees and court cost.
rev.100725



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