

DR. NAME _____

DATE _____

CLINIC/OFFICE _____

DUE DATE _____

TIME _____

PATIENT NAME _____

RESTORATION:

- PFM
 - P-BUTT
- FCC
- Layered ZR (LAVA™)
- E.max®/GC LiSi®
- ZR 100™ HT
- ZR 100™ Premium
- ZR 100™ Classic
- PMMA
- DX Wax-up














IMPLANTS:

- Custom Titanium Abutment
- Custom TI/ZR Abutment
- TiBase

ENCLOSED:

- Impression(s)
- Working Model
- Opposing Model
- Study Model
- Articulator
- Partial

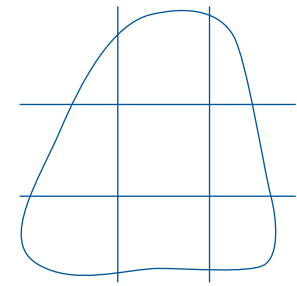
METAL TYPE:

A	B	C	D	E	F	G	H	I	J	K	L	P
												
<input type="checkbox"/> DIE TRIM			<input type="checkbox"/> FRAME TRY-IN				<input type="checkbox"/> BISQUE BAKE TRY-IN					

SPECIAL INSTRUCTIONS:

FINAL SHADE:

Stump Shade: _____



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 collection agency costs, attorneys fees and court costs if this account is referred to collection.

DR. SIGNATURE _____

LICENSE NUMBER _____