

DR. NAME _____

DATE _____

CLINIC/OFFICE _____

DUE DATE _____

TIME _____

PATIENT NAME _____

RESTORATION:

- PFM
 - P-BUTT
- FCC
- EMAX
- Empress®
- LAVA™ PFZ
- LAZR PFZ
- ZR 100 HT
- ZR 100 PREM
- ZR 100 GENERIC
- Smartcrown™ FCZ *(RMGI) Temporary
- PMMA Acrylic
- DX Wax up

IMPLANTS:


- Milled Titanium
- Milled Zirconia
- Custom Cast Abut
- Ti Base
- Emergence Profile
- Gingival Depth of Margin: _____ mm

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

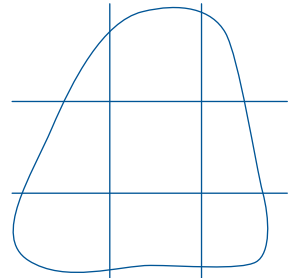


DIE TRIM FRAME TRY-IN BISQUE BAKE TRY-IN

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 _____