



Date:

DOCTOR:

Address:

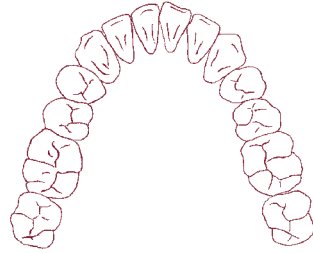
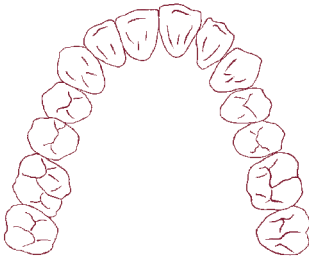
Patient: Age: M F

Required (Date & Time):

Pan:
Received:

TYPE OF RESTORATION:

Shade:	<input type="checkbox"/> Shade details overleaf	Mould:
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REMOVABLE RESTORATIONS

OCCLUSION

- Centric
- Balanced

TOOTH ARRANGEMENT

- Natural
- Follow diagnostic cast

REQUIRED PROCEDURE

- Set Up
- Process
- Reset
- Skeleton

FIXED RESTORATIONS

ALLOY

- Precious
- Semi Precious
- Non Precious

OCCLUSION

- Metal
- Porcelain
- Positive
- Foil Relief

PONTIC

- Ridge Lap
- Modified R. Lap
- Bullet
- Hygenic

MARGINS

- Porc. Butt
- Regular
- Collar

DIE SPACER

- Yes
- No

<input type="checkbox"/> Bisque Bake	<input type="checkbox"/> Glaze & Polish	<input type="checkbox"/> Custom Shade to follow
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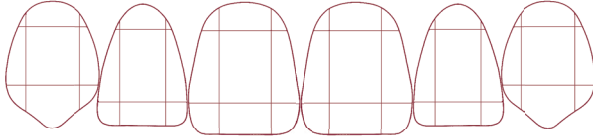
ORTHODONTICS

BITEPLANES Flexguard All Flex Acrylic Wax Up Only

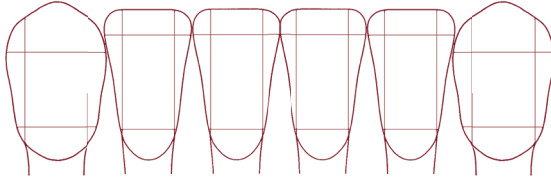
ORTHO APPLIANCE TYPE

Written instructions overleaf

Maxillary anteriors



**SHADE
DETAILS:**



Mandibular anteriors

R_x



Signed..... D.D.S.

LABORATORY USE ONLY

Type of Alloy:

Weight:

Credit:

UM

UI

BR

USM

USU

UCBM

DIES

LM

LI

BB

LSM

LSU

LCBM

ART

OTHER: