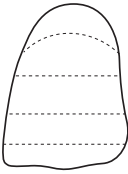







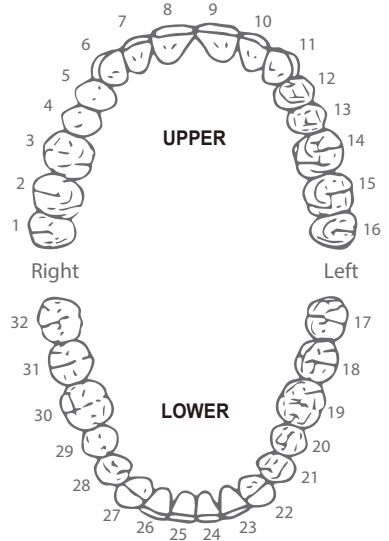
Dr. Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Return Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Age: \_\_\_\_\_

CERAMIC SHADE INSTRUCTIONS	
<b>TRANSLUCENCY</b> <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <b>FISSURE STAIN</b> <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Normal	<b>SHADE:</b> _____ 
PORCELAIN FUSED	FULL MILLED
<input type="checkbox"/> Non-Precious <input type="checkbox"/> Noble <input type="checkbox"/> High Noble: <input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Zirconia	<input type="checkbox"/> Zirconia <input type="checkbox"/> IPS e.max® <input type="checkbox"/> IPS e.max® Multi <input type="checkbox"/> IPS e.max® ZirCAD Prime
FULL CAST	MARGIN DESIGN
<input type="checkbox"/> Non-Precious (Cr-Co) <input type="checkbox"/> Noble Yellow (+ alloy) <input type="checkbox"/> High Noble Yellow (+ alloy)	<input type="checkbox"/> Mesio-Buccal <input type="checkbox"/> Buccal/Facial <input type="checkbox"/> 360°
METAL DESIGN	
	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PONTIC DESIGN	
<b>OVATE</b> 	<b>FULL LAP</b> 
<b>BUCCAL LAP</b> 	<b>SANITARY CONTACT</b> 
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>



Rx

Dr. Signature: \_\_\_\_\_ License No.: \_\_\_\_\_

Date: \_\_\_\_\_

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Net amount of invoice is due within 10 days of order's reception, all balance beyond 30 days are subject to a finance charge of 2%. I agree to pay reasonable attorneys' fees and collection costs if this account is referred to collection.