

728 N. Prospect, Suite 109 - Rockford, IL 61107-3155
 815.964.5940 assureddentallab@aol.com
 assureddentallabinc.com

Doctor _____
 Address _____
 Patient _____

DUE DATE

SHADE
SpectroShade <input type="checkbox"/> YES <input type="checkbox"/> NO

TOOTH NUMBERS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

PRODUCT SELECTION	TYPE OF METAL
<input type="checkbox"/> PORCELAIN TO METAL	<input type="checkbox"/> PFM SEMI PRECIOUS
<input type="checkbox"/> GOLD CROWN	<input type="checkbox"/> PFM HIGH NOBLE
<input type="checkbox"/> IMPLANT CROWN	<input type="checkbox"/> FULL CAST 20%
<input type="checkbox"/> METAL FREE: "Procera", "Lava"	<input type="checkbox"/> FULL CAST 50%
<input type="checkbox"/> BRIDGE	<input type="checkbox"/> FULL CAST 75%
<input type="checkbox"/> EMAX, "Bruxer"	<input type="checkbox"/> OTHER
<input type="checkbox"/> FULL CONTOUR ZIRCONIA	

ADDITIONAL COMMENTS:

IMPLANT DATA		
TOOTH #	IMPLANT TYPE	PLATFORM DIAMETER
XCE or NTN #		

CONSTRUCT AND DELIVER TO THE UNDERSIGNED ONLY THE HEREIN DESCRIBED DENTAL RESTORATION

PERSONAL SIGNATURE OF DENTIST _____ DDS

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