*PLEASE PRINT CLEARLY

DOCTOR'S NAME: _____ DATE _____

PHONE # (_____) _____ LICENSE # _____

PATIENT'S FULL NAME:

(LAST) _____ (First) _____

SEAT DATE REQUESTED – *IN OFFICE? _____ PM

DR. TRIM DIE? ☐ CUSTOM SHADE? ☐ EXPEDITED CASE? *Fee applies ☐

www.adadentallab.net services@adadentallab.net

LAB USE

BLACK CASE PAN

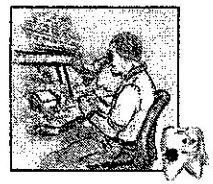
RED SHIP DATE

PRODUCT

ROCKY MOUNTAIN DENTAL LABORATORY

970.267.3400
877.840.9990

2550 Stover Street
Building E, Suite 201
Fort Collins, CO 80525



Providing Craftsmanship, Artistry, and Service in Dental Technology

SPECIFY TOOTH #S:

STUMP SHADE:

SPECIFY DRS SHADE CHOICE BELOW:

DOES PT. BLEACH? YES ☐ NO ☐

PORCELAIN LABIAL MARGIN? ☐

METAL OCCLUSAL? ☐

METAL LINGUAL? ☐

SPECIFY METAL MARGIN BELOW:

***SPECIFY INSTRUCTIONS IF INSUFFICIENT ROOM**

REDUCE OPPOSING ☐ TRIM COPING ☐

CHECK TO REQUEST TECHNICIAN CALL DR ☐

SPECIFY PT INFORMATION BELOW:

MALE ☐ FEMALE ☐

CIRCLE PTS AGE GROUP:

CHILD ADOLESCENT

20s 30s 40s 50s 60s 70+

SPECIFY RESTORATION TYPE:

FULL CAST _____

PFM _____

ZIRCONIA _____

E.MAX _____

SPECIFY IMPLANT INSTRUCTONS:

PLATFORM: _____

SIZE: _____

ABUTMENTS _____

SURGEON'S RX INCLUDED? ☐

SPECIFIC INSTRUCTIONS FOR TECHNICIANS BELOW:

Case Sanitized? ☐ **Specify Special/Precautionary Concerns:**

LAB USE: DATE RECEIVED: _____ TECHNICIAN: _____ OUT: _____ BACK: _____

ITEMS RECEIVED BY DOCTOR: _____

X _____

Doctor's Signature

Thank you for your trust! We appreciate the opportunity to earn your confidence.

Please send additional: ☐ RX Slips ☐ Shipping Labels ☐ Boxes