

TODAY'S DATE:_____ DUE DATE: _____

DR/OFFICE NAME:

PATIENT'S NAME:



FOR BFTTFR RFSUITS:

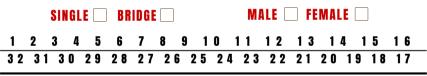
Take & Submit Photos to info@iprodentallab.com

PRFFFRFNCFS:

CONTACT: LIGHT O MEDIUM O HEAVY O TRANSLUCENCY: LIGHT O MEDIUM O HEAVY O OCCLUSAL STAINS: LIGHT () MEDIUM () HEAVY() MARGINS: STANDARD O METAL O PORCELAIN O DISAPPEARING O

IF NOT ENOUGH OCCLUSAL CLEARANCE:

NOYIFY DOCTOR \bigcirc ADJUST TOOTH & MAKE REDUCTION COPING \bigcirc MAKE METAL OCCLUSION \bigcirc ADJUST OPPOSING & MARK \bigcirc



SPECIAL INSTRUCTIONS:

Dr's Signature: _____ License #: ___

