



6421 N. Cutter Circle
 P.O. Box 4755
 Portland, OR 97217-3949
 Phone 503.240.1910
 Toll free 800.422.5779

*Dr. or Lab Name _____

Street _____

City, State & Zip _____

Patient's Name _____

Your Phone # (_____) _____

TYPE OF RESTORATION	
<input type="checkbox"/>	FULL CAST
<input type="checkbox"/>	PORCELAIN TO METAL
<input type="checkbox"/>	COMPOSITE
<input type="checkbox"/>	ALL PORCELAIN
<input type="checkbox"/>	IMPLANT CASE
<input type="checkbox"/>	DENTURE
<input type="checkbox"/>	PARTIAL

METALS	
<input type="checkbox"/>	HIGH NOBLE
<input type="checkbox"/>	NOBLE
<input type="checkbox"/>	PRED. BASE

* PLEASE USE THE NAME
 THAT'S ON YOUR ACCOUNT.
Thank You

TODAY'S DATE:

SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
AGE: <input type="checkbox"/> YOUNG <input type="checkbox"/> MIDDLE

SHADE	
PORC.	PLASTIC

RACE:	PERSONALITY:
	<input type="checkbox"/> DELICATE
	<input type="checkbox"/> MEDIUM
	<input type="checkbox"/> VIGORUS

STAINING (DIAGRAM)

<input type="checkbox"/>	WAX TRY-IN
<input type="checkbox"/>	METAL TRY-IN
<input type="checkbox"/>	BISQUE BAKE
<input type="checkbox"/>	FINISH CASE

Rx
 INSTRUCTIONS:

Date Wanted: / /	Time: AM / PM
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REPAIRS & RELINES If called in before 10:00 am: Simple Repairs and Regular
 (Local pickups) Relines can be returned to you by 4:30 pm the same day.

<input type="checkbox"/> CALL DOCTOR*	* UPDATE NOTES ON BACK FOR
<input type="checkbox"/> CALL WITH DELIVERY DATE*	<u>EVERY</u> CHANGE TO Rx

DR. SIGNATURE	LICENSE NO.
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