Due Date Case # Patient

LAB USE ONLY LAB USE ONLY

Doctor's Information

Name _____ Address _____

City and State _____ Telephone _____

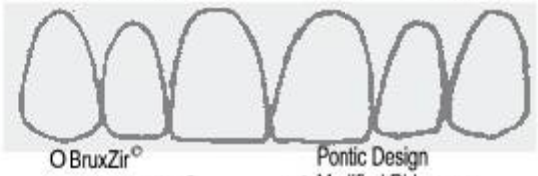
Patient Information

Name _____ O Male O Female Age ____

Cement Date: _____ am / pm O Mon O Tue O Wed O Thur O Fri O Sat

Case Design Please Allow Ten (10) Working Days

Tooth Numbers to be Restored _____ __ Basic Shade __ Stump Shade



O BruxZir©
O E Max Zirmax©
O E Max Press
O E Max Press/Layered
O Feldspathic Veneers
O Diagnostic Wax Up

Pontic Design
O Modified Ridgecap
O Ovate
O Sanitary

O Soft Tissue Model

Anterior Characteristics

Incisal Transluncency	O Heavy O Medium O Light O None
Show Mammalons	O Heavy O Medium O Light O None
Surface Texture	O Heavy O Medium O Light O None
Cervical Blending	O Heavy O Medium O Light O None
Occlusal Stain	O Heavy O Medium O Light O None
Hypocalcification	O Heavy O Medium O Light O None

Ideal Smiles
Sending a smile your way!

Work Authorization

Doctors Signature Authorizing the Specified Work

_____

Date Sent _____

DDS License # _____

Please send:
O RX Forms
O Boxes
O Airbills

Ideal Smiles 1015 Sage Drive, Pleasant Grove UT 801-427-9230 Office 801-604-5110 Mobile IdealSmilesForYou@gmail.com

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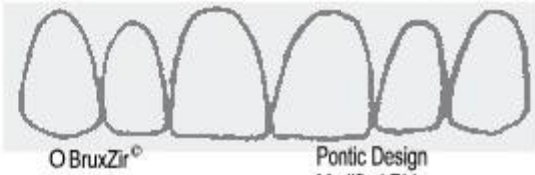

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