



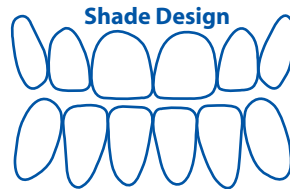
5658 W. 73<sup>RD</sup> Street  
 Indianapolis, IN 46278  
 (317) 802-7878  
 Toll Free: (866) 586-4336

Dr. \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Patient: \_\_\_\_\_  Male  Female  
 Due Date: \_\_\_\_\_ by 5:00pm

<input type="checkbox"/> <b>FULL CAST</b> <input type="checkbox"/> Premium High Noble <input type="checkbox"/> High Noble (yellow) <input type="checkbox"/> Noble (yellow) <input type="checkbox"/> Noble (white) <input type="checkbox"/> Non-precious	<input type="checkbox"/> <b>PORCELAIN TO METAL</b> <input type="checkbox"/> High Noble (yellow) <input type="checkbox"/> High Noble (white) <input type="checkbox"/> Noble (white) <input type="checkbox"/> Non-precious <input type="checkbox"/> Porcelain Butt Margin	<input type="checkbox"/> <b>METAL FREE</b> <input type="checkbox"/> Layered Zirconia <input type="checkbox"/> Full Contour Zirconia <input type="checkbox"/> Laminate/Veneer <input type="checkbox"/> E.max				
<b>PONTIC DESIGN</b> 		<b>If NO Occlusal Clearance</b> <input type="checkbox"/> Metal Occlusion/Stop <input type="checkbox"/> Reduction Coping <input type="checkbox"/> Adjust Opposing				
<b>METAL MARGIN DESIGN</b> Anterior Posterior 		<table border="1"> <tr> <th>Tooth #</th> <th>Shade</th> </tr> <tr> <td colspan="2" style="text-align: center;">Shade Guide</td> </tr> </table>	Tooth #	Shade	Shade Guide	
Tooth #	Shade					
Shade Guide						

Please Call

Notes:



Signature \_\_\_\_\_ License# \_\_\_\_\_

Return the white and yellow copies with the case. Retain the pink copy for your file.



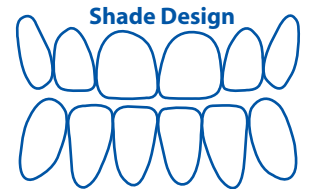
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