



CREATIVE DENTAL LABORATORY, INC.

14201 N. 87th STREET, SUITE 105 ■ SCOTTSDALE, AZ 85260 ■ (480) 948-0456
1-800-666-2354

DR. _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT'S NAME _____ AGE: _____ SEX: M F

TYPE OF RESTORATION:

- | | | | |
|--------------------------------|----------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> FULL | <input type="checkbox"/> PARTIAL | <input type="checkbox"/> TRY-IN | <input type="checkbox"/> FINISH |
| <input type="checkbox"/> UPPER | <input type="checkbox"/> UPPER | <input type="checkbox"/> REPAIR | <input type="checkbox"/> RELINE |
| <input type="checkbox"/> LOWER | <input type="checkbox"/> LOWER | <input type="checkbox"/> JUMP | <input type="checkbox"/> ADD-ON |

OTHER _____

TEETH

- | | |
|-----------------------------------|----------------------------------|
| SHADE _____ | MOLD _____ |
| ANTERIOURS | POSTERIOURS |
| <input type="checkbox"/> NEW HUE | <input type="checkbox"/> PORC |
| <input type="checkbox"/> BIOBLEND | <input type="checkbox"/> PLASTIC |
| <input type="checkbox"/> BIOFORM | <input type="checkbox"/> IPN |
| <input type="checkbox"/> BIOTONE | |
| OTHER _____ | |

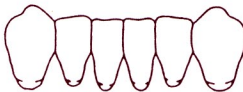
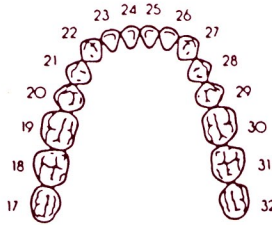
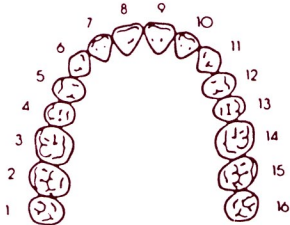
INSTRUCTIONS:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> BASE PLATES | <input type="checkbox"/> IVOCAP LIGHT |
| <input type="checkbox"/> WAX RIMS | <input type="checkbox"/> IVOCAP DARK |
| <input type="checkbox"/> RE-SET | <input type="checkbox"/> DURA-SOFT |
| <input type="checkbox"/> POST DAM | <input type="checkbox"/> SOFT LINER |
| <input type="checkbox"/> PALATAL RELIEF | <input type="checkbox"/> CLEAR |
| <input type="checkbox"/> RUGAE | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> STIPPLE | |
| <input type="checkbox"/> SS CLASPS | |
| <input type="checkbox"/> GOLD CLASPS | |
| <input type="checkbox"/> OTHER | |

DATE DUE: TRY-IN	AM PM	FINISH	AM PM
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DESIGN

ADDITIONAL INSTRUCTIONS:



SIGNATURE _____

LICENSE NO. _____

TERMS: Orders not paid within 30 days of statement are subject to a delinquency charge of 2 percent per month. The dentist will be responsible for all collection costs including attorney's fees incurred in the event that account collection becomes necessary.