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Dr. _____

Patient Name: _____

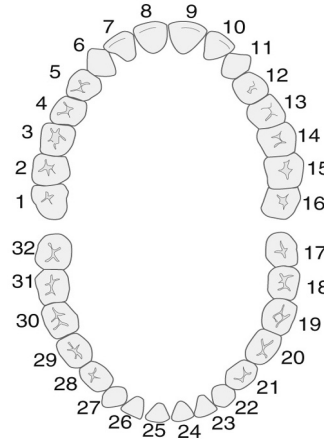
Age: ___ M / F

Today's date: ___/___/___ Return Date: ___/___/___

Fixed Restorations

- Full Zr
- PFZr
- PFM
- E-max
- Veneers
- Full Cast
- Alloy
- Temps
- Diagnostic
- Printed Model
- Implants
 - * Screwed
 - * Cemented

Shade: _____



Removables

Cast Metal Partial

- Frame Only
- Frame & Bite Block
- Frame & Wax Setup with teeth
- Flexible & Frame
- TCS / Valplast Partial

Dentures

- Custom Tray
- Bite Block / Rim
- Set-up Teeth in Wax
- Process Denture
- Flipper
- Nestbit TCS
- Valplast Flexible Denture (TCS)

Guards & Bleaching

- Retainer
- Hard Nightguard
- Hard/Soft Nightguard
- Bleaching Tray

Surgical guide

Palatal Stent

Reline

Repair -describe below

Enclosed:

Photos:

- | | |
|------------------------------------|-------------------------------|
| <input type="radio"/> Impressions | <input type="radio"/> Website |
| <input type="radio"/> IOS | <input type="radio"/> E-mail |
| <input type="radio"/> Study Models | <input type="radio"/> Prints |
| <input type="radio"/> Opposing | <input type="radio"/> None |
| <input type="radio"/> Bite | |
| <input type="radio"/> Articulator | |
| <input type="radio"/> Parts | |
| <input type="radio"/> Implant Part | |

If Insufficient Room: Reduce & Mark Please Call Reduction Coping

ALL IMPRESSIONS & PATIENT RELATED PICK UPS MUST BE CLEANED & DISINFECTED PROPERLY.

Case Description:

Rework / Alteration

Shade Change

Contact Adjust

Work authorization order. Construct and deliver to me the herein described dental restoration.

Signature : _____ License #: _____

Address: _____ City: _____ State: _____ Zip code: _____ Phone # _____

By signing this I agree to accept full responsibility of payment for the above restoration.

EACH PRESCRIPTION MUST BE COMPLETED AND SIGNED