



336-763-2841 voice
 336-763-2848 fax
 absolutewest@absolutedentalservices.com
 absolutedentallab.com
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PREP DATE: _____

DATE NEEDED: _____

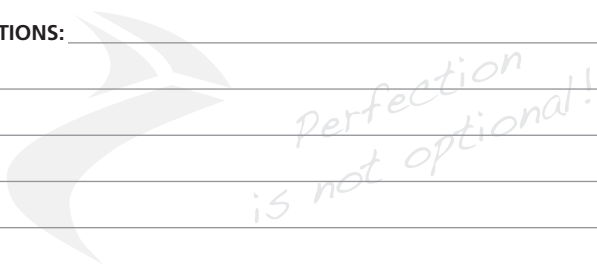
SPECIFY TIME NEEDED: _____

(Please follow our monthly delivery schedule)

DR: _____ PATIENT: _____

TEETH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
NUMBERS	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
DIGITAL IMPRESSION <input type="checkbox"/>		SYSTEM USED _____															
METAL FREE		<input type="checkbox"/> LAB TO USE BEST MATERIAL FOR STRENGTH AND ESTHETICS <input type="checkbox"/> ENVISION ZIRCONIA <input type="checkbox"/> ENVISION VENEER/INLAY <input type="checkbox"/> ADZIR ZIRCONIA <input type="checkbox"/> E*MAX VENEER/INLAY <input type="checkbox"/> E*MAX DISILICATE <input type="checkbox"/> FELDSPATHIC VENEER															
PFM ALLOY TYPE		<input type="checkbox"/> POSTERIOR FLAT RATE NOBLE PFM - ONLY SINGLE UNITS <input type="checkbox"/> WHITE NOBLE <input type="checkbox"/> YELLOW HIGH NOBLE <input type="checkbox"/> WHITE HIGH NOBLE <input type="checkbox"/> BASE / NON-PRECIOUS															
PFM MARGIN TYPE		<input type="checkbox"/> LINGUAL METAL COLLAR SHOW NO METAL ON FACIAL <input type="checkbox"/> 360° SHOW NO METAL <input type="checkbox"/> FACIAL PORCELAIN BUTT <input type="checkbox"/> 360° METAL COLLAR <input type="checkbox"/> LING. SCALLOP DESIGN															
SPECIALTY CASES		<input type="checkbox"/> METAL OCCLUSAL <input type="checkbox"/> EXISTING PARTIAL <input type="checkbox"/> SURVEY CROWN <input type="checkbox"/> CROWN WITH REST															
FULL CAST CROWNS		<input type="checkbox"/> POSTERIOR FLAT RATED NOBLE FULL CAST YELLOW <input type="checkbox"/> 40% YELLOW GOLD <input type="checkbox"/> NON-PRECIOUS YELLOW GOLD <input type="checkbox"/> 60% YELLOW GOLD <input type="checkbox"/> WHITE NOBLE ALLOY <input type="checkbox"/> 80% YELLOW GOLD <input type="checkbox"/> WHITE HIGH NOBLE ALLOY															
IMPLANT PLATFORM		COMPANY: _____										IMPLANT SIZE: _____					
PATIENT INFO		<input type="checkbox"/> SHADE PICS SENT TO absolutewest@absolutedentalservices.com <input type="checkbox"/> PATIENT TO CALL LAB <input type="checkbox"/> MALE SHADE: _____ <input type="checkbox"/> FEMALE AGE: _____															
CONTACT DDS		<input type="checkbox"/> TECHNICIAN TO CALL REGARDING CASE															

SPECIAL INSTRUCTIONS: _____



DENTIST SIGNATURE

DENTIST LICENSE

2601 Oakcrest Ave., Suite E | Greensboro, NC 27408
 By signing and submitting this prescription the undersigned is agreeing to pay for the item(s) prescribed.