TRADITIONAL DENTAL LAB

Dental Laboratory Work Authorization

918 493 0211
905 S. 9th St, Suite B
Broken Arrow, OK 74012

Date _____

Office _____

Address _____

DESIGN CASE HERE

UPPER

_____

_____

LOWER

Designate Right and Left

Patient _____

Type Restoration _____

Shade _____

Mould _____

Material _____

Date Wanted:

Try In _____

Finish _____

Please print or write legibly and make instructions as complete as possible. Use reverse side if necessary.

SPECIAL INSTRUCTIONS

Signature _____ D.M.D. D.D.S.

Address _____

Dental License No. _____

MUST BE RETAINED BY DENTAL LABORATORY FOR 3 YEARS