to:

Regional Dental Lab

207 West 39th St. Sioux Falls, SD 57105
Telephone: (605)332-6685

from:

Work Order Number: ______________________ Date: __________

Dr: ______________________

Address ______________________

City ______________________ State ________ Zip __________

Patient's Name Or Identification Number ______________________

Type of Restoration ______________________

Date Wanted: Try-in ______________ AM - PM Finish __________

BRAND, SHADE & MOULD OF TEETH TO BE USED

ANTERIOR
- ❑ PORCELAIN
- ❑ PORTRAIT IPN
- ❑ BIOBLEND®
- ❑ BIOFORM®
- ❑ NEW HUE®

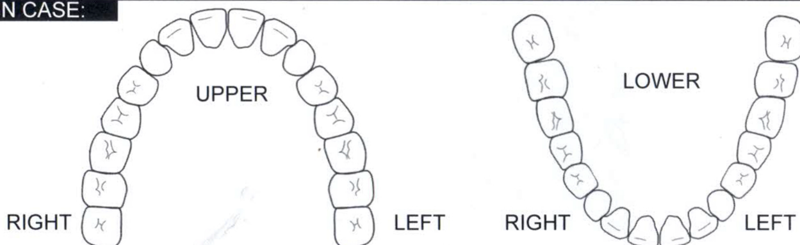
POSTERIOR
- ❑ PORCELAIN
- ❑ PORTRAIT IPN
- ❑ 33º
- ❑ 20º
- ❑ 10º FUNCTIONAL®
- ❑ 0º RATIONAL®

		ANTERIOR	POSTERIOR
UPPER	SHADE	MOULD	MOULD
LOWER	SHADE	MOULD	MOULD

ALMA GUAGE READING X: ______________ (VERTICAL) Y: ______________ (HORIZONTAL)

FINISH CASE IN: ❑ LUCITONE 199® ❑ LUCITONE® CHARACTERIZED ❑ LUCITONE® FRS FLEXIBLE RESIN

DESIGN CASE:



INSTRUCTIONS:

Dentists License Number: ______________________ Date: __________

Personal Signature of Dentist: ______________________