

SO# _____ BIN# _____

IMP FRM SHD BITE
 OPP ABT CRN _____

(For office use only)

DOCTOR _____ TODAY'S DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Male / Female

PATIENT _____ GENDER _____

DATE REQUESTED

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y

Allow 15 Business Days for Delivery

REQUIRED:

- Full arch impressions
- No triple trays accepted
- Bite registration with rigid material

Digital photos strongly recommended for optimal shade results.

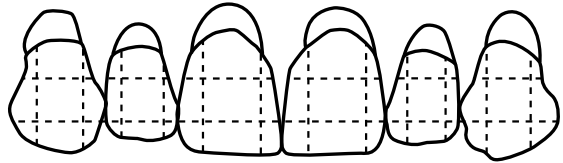
INDIVIDUAL / BRIDGE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

SHADE:

(Please use Vita equivalent)

Stain? YES NO



RESTORATION:

Fixed

- Integrated Abutment Crown™
 Polyceramic Crown
 All-Ceramic
 PFM » Alloy: HN NP

Bridge work must be tried in prior to finish.

Removable Overdenture

- Brevis™ / Locator® / O-Ring
 Bar

Surgical

- Lingual Template
 Vacuum-Formed Template

Rx:

Payment: MasterCard Visa American Express COD

Card Number: _____ Expires: _____

Signature: _____ License Number: _____

(Required)

Each Lab Authorization Slip constitutes a complete and separate transaction to be invoiced and paid as such. By signing I understand and accept the warranty terms and conditions of the Bicon Dental Lab. See lab invoice for warranty, terms, and conditions.