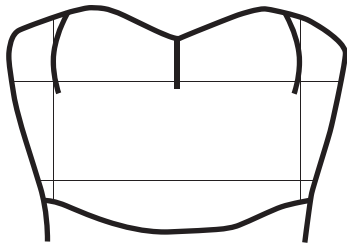
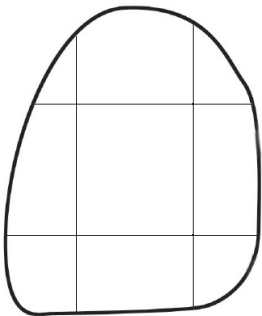




Dentist: _____
Address: _____

Patient Name: _____ Telephone: _____
ID N°: _____
Age: M F ND/Prep Shade: _____
Basic Shade: _____ CAD Material: _____



Refer to Smile Makeover form
Refer to Diagnostic Wax-up form
Amendments to original order (if any)

Date required back (please allow 10 working days) _____ am / pm

All Ceramic Composite Zirconia
PFM Precious PFM Non Precious

Instructions: _____

FOR LAB USE ONLY
ENCLOSURES
Alginate U/L _____
Rubber U/L _____
Study models U/L _____
Bite record _____
Images _____
STLs _____

CONTRACT RECEIVED & ORDER ACCEPTED
Signed: _____ Date: _____ Job No. _____
Operation Inits Operation Inits Operation Inits
Disinfection Models/articulation Die Trim
Design Process Acrylic/vinyl Trim/Polish
Framework Porcelain/Composite Glaze/Polish
FINAL DELIVERABLE CHECKED AND CLEARED FOR DESPATCH
Signed: _____ Date: _____

Statements:
1: This custom made device is for the exclusive use of the patient named above and conforms to the relevant essential requirements set out in Annex 1 of the Medical Devices Directive (93.42/EEC).
2: Any relevant essential requirements that have not been met will be listed overleaf with a description with a description of the reason.
3: All goods are supplied in a non-sterile condition unless otherwise stated and should not be subject to extremes of hot or cold.