



Type	U	Cast	Finish

4311 Research Way, Corvallis, OR 97333
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www.obriendentallab.com

Doctor _____ Date _____
(please print clearly)

Patient _____ Sex _____ Age _____

Delivery Date

- | | |
|--------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Porcelain to Metal (please specify) | <input type="checkbox"/> Full Cast Gold |
| <input type="checkbox"/> Z Core® | <input type="checkbox"/> Goldtech® Bio 2000 |
| <input type="checkbox"/> Procera® | <input type="checkbox"/> IPS Empress® |
| <input type="checkbox"/> All Porcelain (crown or veneer) | <input type="checkbox"/> Cristobal+® |

Shade:



Photos included: yes no e-mailed

Please describe the case: (use reverse if needed)

Doctor Signature _____ License Number _____

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