

Cardinal Dental Laboratory, Inc.

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DR. _____ DUE DATE _____

PATIENT _____ SHADE _____

Rx

T
W
MF
OP
P
C
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FP
QC

- | | | |
|---|---|---|
| <input type="checkbox"/> Precious | <input type="checkbox"/> Semi-Precious | <input type="checkbox"/> Non-Precious |
| <input type="checkbox"/> Porcelain Margin | <input type="checkbox"/> Metal Margin | <input type="checkbox"/> Regular Margin |
| <input type="checkbox"/> Metal Occlusal | <input type="checkbox"/> Porcelain Occlusal | <input type="checkbox"/> Metal Lingual |

PONTICS:











Signature _____ License # _____