



# Springfield

DENTAL LAB

557 B Street - Springfield, Oregon 97477

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(Cell) 541-912-9635

3701

Date \_\_\_\_\_ Finish Date \_\_\_\_\_ am/pm

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Patient \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Bite \_\_\_\_\_

Shade \_\_\_\_\_ Tooth # \_\_\_\_\_

Fixed  
CAD/CAM

Additional Instructions:

- Full Contour Zirc.
- Zirc. Core w/Porc.
- Zirc. Core
- Implant Stent
- PFM
- Full Gold
- Metal Lingual/Occlusion
- Metal Margin
- Porc. Margin
- E-Max

Dr. Signature \_\_\_\_\_

License No. \_\_\_\_\_