

Dental Laboratory Prescription for Laboratory work authorization by Dentist only
 9904 Cerro Alto Cv.
 Austin, TX 78733-2527
 (512)263-2254
 TX License #1333
rn rteeth@aol.com www.rnrrestorations.com

Patient Name: _____ Prep Date: _____

Due Date: _____

Doctor: _____ (Please Schedule with Lab)

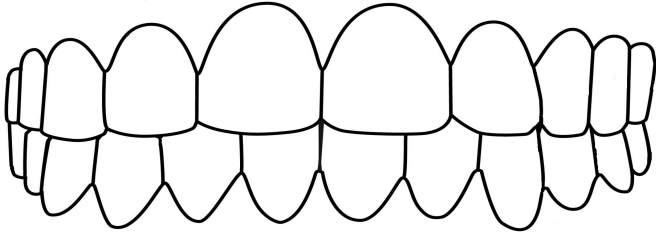
Tooth #: _____ Chair Side Service
 Shade: _____ Stump Shade: _____

Restoration Type:

BruxZir <input type="checkbox"/> Full Contour <input type="checkbox"/> Framework w/ Porcelain <input type="checkbox"/> Inlay/Onlay <input type="checkbox"/> Bridge	EMAX <input type="checkbox"/> CAD <input type="checkbox"/> Press <input type="checkbox"/> Bridge Block Used: _____
PFM <input type="checkbox"/> Yellow gold <input type="checkbox"/> Precious <input type="checkbox"/> Noble <input type="checkbox"/> Porcelain Margin	FULL GOLD <input type="checkbox"/> Yellow <input type="checkbox"/> White <input type="checkbox"/> Noble <input type="checkbox"/> High Noble
IMPLANT <input type="checkbox"/> Ti Base <input type="checkbox"/> Two Piece Hybrid <input type="checkbox"/> One Piece Screw Retained	ABUTMENT <input type="checkbox"/> Titanium <input type="checkbox"/> Zirconia
TEMPORARY <input type="checkbox"/> Composite <input type="checkbox"/> Resin <input type="checkbox"/> Lava Ultimate <input type="checkbox"/> Vita <input type="checkbox"/> Ivoclar	<input type="checkbox"/> DIAGNOSTIC WAX-UP <input type="checkbox"/> Open Bite ____ mm

Lot # (For Lab use) _____ Dwts. _____

Shade Details:



Doctor's Signature: _____ License # _____

Limited Warranty. Guaranteed to fit impression provided. Cost of collection of any account will be paid by the customer. Terms: Due upon receipt (1st of the following month); 2% service charge if unpaid after the 15th. Subject to outsourcing, fees may change without notice.

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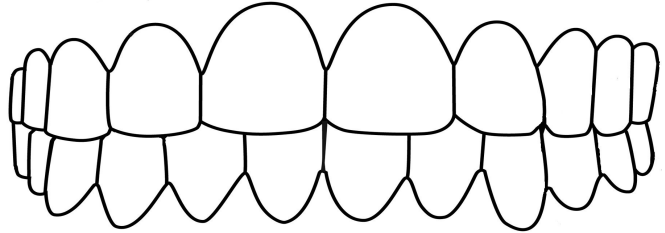
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