trout dental LABORATORY

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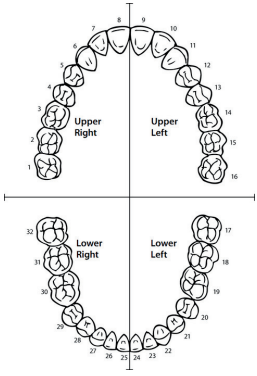
www.troutdental.com

AM/PM

LAB USE ONLY

❑ **TRY IN**
❑ **FINISH**

DOCTOR	
ADDRESS	
TELEPHONE	
PATIENT NAME	
AGE ❑ Male ❑ Female	**DATE REQUESTED**
DATE SENT	**TIME** AM PM



TYPE OF CASE:

Full Denture	Partial Denture
❑ Upper	❑ Upper
❑ Lower	❑ Lower

TEETH:
❑ Acrylic ❑ Porcelain

Shade _____
Mould _____

TYPE OF PARTIAL:
❑ All Acrylic
❑ Metal
❑ Flexible

TYPE OF CASE:
Crown & Bridge

Porcelain Fused to Metal
❑ Non-Precious
❑ Noble (Semi-Precious)
❑ White High Noble
❑ Gold High Noble

Zirconia
❑ All Zir (Solid Zirconia)
❑ Inivizion (Porc/Zirc)

All Ceramic
❑ IPS E-Max
❑ IPS Empress
❑ Laminate Veneers

❑ ***CASE HAS BEEN DISINFECTED***

❑ **CALL DOCTOR**

PLEASE SEND:
❑ Prescriptions
❑ Shipping boxes
❑ Shipping labels

℞ INSTRUCTIONS

DENTIST'S LICENSE NO._____**DATE**_____

PERSONAL SIGNATURE OF DENTIST_____