

DENTECH

Ceramic • Restorations

490 POST STREET, SUITE 555

S.F. CA 94102

Member California Dental
Laboratory Association

415 - 989 - 4651

Garabet A. Kantarci

FROM _____ WORK ORDER NUMBER _____ DATE _____

DR. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT'S NAME OR IDENTIFICATION NUMBER _____

TYPE OF RESTORATION _____

DATE WANTED: TRY-IN _____ AM _____ PM FINISH _____

(CONSTRUCT AND DELIVER TO THE UNDERSIGNED ONLY THE HEREIN DESCRIBED DENTAL RESTORATION.)

DESIGN INSTRUCTIONS

PONTICS

ANTERIOURS

Metal coping

Metal lingual

Metal lingual



POSTERIOURS

Metal coping
All porcelain coverage

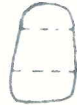
Metal occlusal
Excluding buccal cusp

Metal occlusal
Including buccal cusp



METAL MARGIN
 HAIRLINE OR _____ MM
 METAL PORCELAIN
JUNCTION MARGIN

SHADE



INSTRUCTIONS

DENTIST'S LICENSE NUMBER _____ DATE _____, 20 _____

PERSONAL SIGNATURE OF DENTIST