



3515 Buffalo Road, Suite 30 • Rochester, NY 14624
 585-730-5100 Office • 585-730-5095 Fax
 Info@cranedentallab.com

Dr. _____

Address _____

City, Zip _____ Phone _____

Patient _____ M ___ F Age _____

Date
Return Date & Time

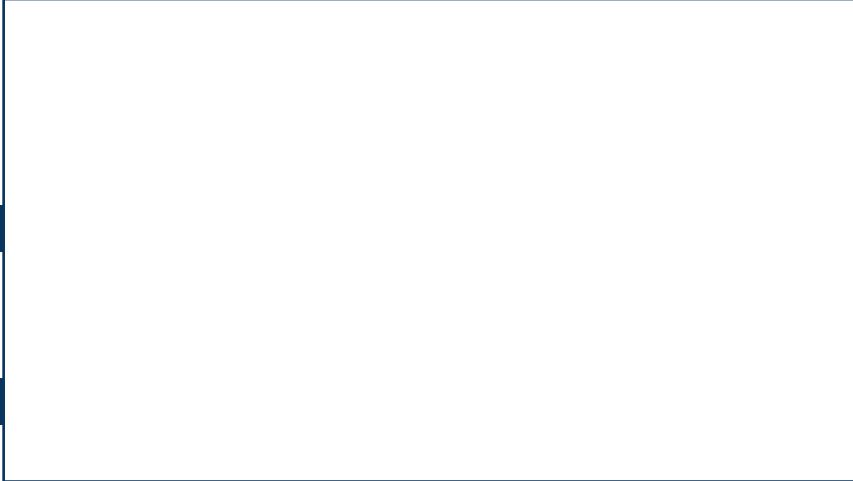
REMOVABLE
<input type="checkbox"/> Custom Tray <input type="checkbox"/> Occlusal Rim <input type="checkbox"/> Set Up <input type="checkbox"/> Process <input type="checkbox"/> Wrought Wire Acrylic Partial <input type="checkbox"/> Clasps <input type="checkbox"/> Flipper <input type="checkbox"/> Cast Partial <input type="checkbox"/> Dura Flex <input type="checkbox"/> Overdenture <input type="checkbox"/> Hybrid

REPAIRS & RELINES
<input type="checkbox"/> Same Day <input type="checkbox"/> Repair <input type="checkbox"/> Reline <input type="checkbox"/> Rebase (Jump) <input type="checkbox"/> Soft Liner

NIGHT GUARDS
<input type="checkbox"/> Hard Night Guard <input type="checkbox"/> Thermoflex Guard <input type="checkbox"/> Deprogrammer/NTI <input type="checkbox"/> Anterior Segmented Splint <input type="checkbox"/> Erko Dual Hard/Soft Guard <input type="checkbox"/> W/Anterior Guidance

SLEEP APPLIANCES
<input type="checkbox"/> Sapphire Dorsal <input type="checkbox"/> Sapphire Herbst <input type="checkbox"/> EMA <input type="checkbox"/> Lamberg Sleepwell <input type="checkbox"/> Tap Appliance <input type="checkbox"/> W/Anterior Ramp <input type="checkbox"/> Clasps for Elastics

Upper Lower Upper & Lower Tooth #'s _____
 Shade _____ Mold _____ Acrylic _____ Metal Try In _____
 Economy Teeth _____ Standard Teeth _____ Premium Teeth _____



UPPER

RIGHT LEFT

*Please Remember ---
Shade, Bite & Opposing Model*

Please Send

Prescriptions

Mailing Labels

Boxes

**INTRAORAL SCANS
PLEASE CALL LAB**

LOWER

LEFT RIGHT

Signature _____ License Number _____

IMPLANTS	
<input type="checkbox"/> Stock Abutment <input type="checkbox"/> Custom Abutment ___ Titanium ___ Zirconia	<input type="checkbox"/> Implant Type _____ <input type="checkbox"/> Diameter _____

PARTS
<input type="checkbox"/> Manufacturer Parts <input type="checkbox"/> FDA Certified Parts <input type="checkbox"/> After Market Parts

ALL CERAMIC	
<input type="checkbox"/> Full Zirconia <input type="checkbox"/> Layered Zirconia <input type="checkbox"/> Emax	<input type="checkbox"/> Layered Emax <input type="checkbox"/> Veneers <input type="checkbox"/> Stump Shade _____

PFM'S	FULL CAST
<input type="checkbox"/> Non Precious <input type="checkbox"/> Noble <input type="checkbox"/> High Noble White	<input type="checkbox"/> Noble Yellow <input type="checkbox"/> NP Yellow <input type="checkbox"/> Non Precious

MARGINS	EMBRASURE
<input type="checkbox"/> Metal Margin <input type="checkbox"/> Hairline <input type="checkbox"/> Covered <input type="checkbox"/> Collarless	<input type="checkbox"/> Open <input type="checkbox"/> Normal <input type="checkbox"/> Closed

OCCLUSION
<input type="checkbox"/> In Occlusion <input type="checkbox"/> Slightly Out of Occlusion <input type="checkbox"/> Out of Occlusion <input type="checkbox"/> Metal Occlusion

TEMPORARIES
Tooth # _____ Pontic # _____ <input type="checkbox"/> 1mm reduction <input type="checkbox"/> 2mm reduction