

MERRIMAC DENTAL

Laboratory, Inc.

PAN NUMBER _____ DATE _____

DOCTOR _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

DATE WANTED _____

TIME _____ AM PM
(if needed same day) (circle)

I _____ BB _____ AR _____ TE _____

B _____ MT _____ AT _____ CR _____

O _____ CT _____ WT _____ BR _____

D _____ WM _____ FR _____ ST _____

P _____ SM _____

(Construct and deliver to the undersigned only the herein described dental restoration.)

PATIENT NAME _____

OR ID NUMBER: _____

CASE NO _____

CHECK BASIC FACE FORM:

- Square
- Square Tapering
- Tapering
- Ovoid
- TRY-IN FINISH

CHECK FACIAL ASYMMETRY:

- Dominant Right Side
- Dominant Left Side
- Male Female
- Vigorous Soft

DENTURE TEETH:

- Economy Standard Premium

ANTERIOR:

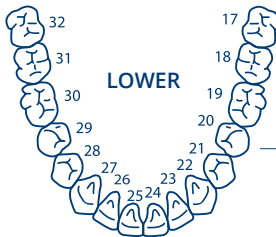
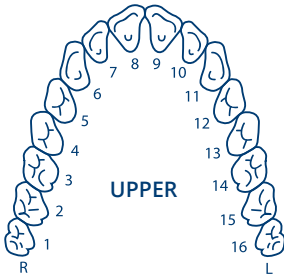
Upper	Shade	Mould
Lower	Shade	Mould

PROCESS:

- Economy Premium
- Standard Flexible

POSTERIOR:

Upper	Shade	Mould
Lower	Shade	Mould



DESIGN CASE ON ILLUSTRATION

Indicate Teeth To Be Extracted
Indicate Rest & Clasp

DOCTOR'S SIGNATURE _____ LIC. NO. _____

All balances beyond 30 days are subject to finance charge. I agree to pay reasonable attorney's fees and collection costs if this account is referred to collection.