

Dr. _____

Case #

Date & Time Required _____

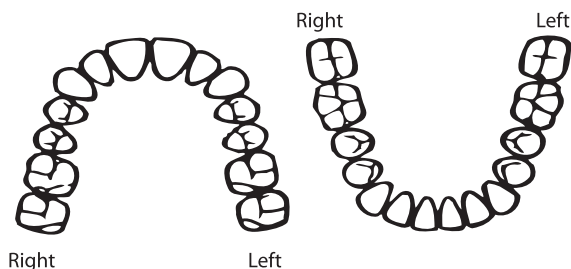
Acc #			For Lab Use Only				Case #	
M	T	B	NG	SS	D	IP	A	BT
Pan #							FW	P/O

Patient _____

Shade _____ Mould _____

Instructions

- Cast Partial
- Over Denture
- Acrylic Partial
- Complete Denture
- Pro-flex System



- Bite Block
- Frame Try-in
- Reline
- Custom Tray
- Setup Try-in
- Rebase
- Finish
- Repair

Signature _____

Date _____

CROWN DENTAL STUDIO

13541 102 Avenue, Unit 201, Surrey, BC V3T 4X8

Tel: 604.588.0099 • TollFree: 888.588.9922 • Fax: 604.589.6268 • gocrowndental.ca

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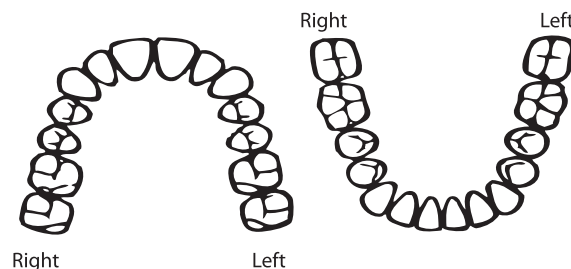
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