

Date



ITO & KOBY DENTAL STUDIO

6402 CASTLEPLACE DR.
INDIANAPOLIS, IN 46250
PHONE (317) 849-5143
WATS (800) 288-6684
FAX (317) 849-5530

RETURN
CASE BY

PLEASE ALLOW ADDITIONAL TIME FOR PICK-UP AND DELIVERY.

Doctor

Address

Phone

Patient Name

Age

Sex

FIXED

DENTALLOY™ SELECTION - PLEASE CHECK

FULL CAST ALLOY

- Yellow / High Noble
- Yellow / Noble
- White / Noble
- Predominantly Base

PONTIC DESIGN

Regular

Modified

Sanitary

High Water



PORCELAIN ALLOY

- Captak®
- Yellow / High Noble
- White / High Noble
- White / Noble
- Predominantly Base

Indicate Characterization If Any



PORCELAIN COVERAGE

- Full Porcelain Coverage
- Metal Occlusal
- Porcelain Butt Margin

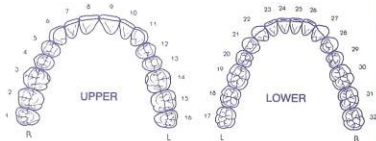
METAL
DESIGN

SHADE

PARTIAL & DENTURE

NTI-less *plus*™

Valplast®



Premium Wironium® Frame

Thermo-Guard™

RETURN STAGE - PLEASE CHECK

PARTIAL

- Frame Only
- Bite Blocks
- Set-up (Wax)
- Finish

DENTURE

- Custom Tray
- Bite Blocks
- Set-up (Wax)
- Finish
- Premium Finish

	MOULD		TYPE		SHADE
	Anterior	Posterior	Porcelain	Plastic Composite	
UPPER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LOWER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PLEASE GIVE ALL NECESSARY INFORMATION

Instructions: If Insufficient Room (Check One): Reduce And Mark Call

I agree full remittance of charges incurred by this prescription is payable within ten (10) days of receipt of statement and further agree to pay all costs incurred in collection should I default, including without limitation, reasonable attorney's fees and a monthly service charge of 1 1/2% of outstanding balance.

Doctor's Signature

License No.

PLEASE SEND: PRESCRIPTIONS SHIPPING LABELS BOXES OTHER _____