Gettihg Started

Note: Dear Doctor ,please print and fill up the following for for the best of our future colaboration.

Return With Your First Case

Your Contact Information

Doctor:		Address:	
Phone:		City/Prov:	
Fax:		E-mail:	
Operating Hours:			

Your Preferences

Contacts: Broad Point Normal Tight Light

Occlusal Contact With Opposing Teeth?

Positive Contact	
Foil Relief	
Out of Occlusion	

Aditional Comments

Past Problems with Other Labs ?

Shade		Contacts		Margins	
Occlusion		Fit		Contour	
Service		Other			