



Amko Dental Lab LLC.
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 Tel: 425) 775-1791

PAN. NO.

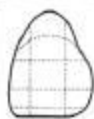
Dr. _____

Patient _____ Sex: M F Age: _____
PLEASE PRINT CLEARLY

Due Date : _____ * Please make sure that the due date is 1-2days before Pt's appointment date.

TEETH NUMBERS TO BE WORKED ON

PATIENT'S RIGHT SIDE								PATIENT'S LEFT SIDE							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
21	22	23	24	25	26	27	28	34	33	32	31	30	29	28	27



SHADE : _____
 TOOTH NO. : _____

ALLOY

NP
 SP
 WHN
 YHN

RESTORATION

PFM
 PFC (Inlay / Onlay)
 Lava
 Implant
 IPS e-Max (Zir-Press, Press, CAD)
 IPS Empres (Stain, Layering)
 Other All-Ceramic

Rx DESCRIPTION : _____

METAL FRAME TYPE

Standard
 Metal Occlusal
 Metal Lingual
 Metal Margin
 Porcelain Built-Margin
 No Metal Margin

OCCLUSAL STAIN

None Medium
 Light Dark

DENTURE

Custom Tray
 Frame Work (Max, Man)
 Wax Rim
 Set Up Tooth
 Flipper
 Valplast
 Nightguard

Signature : _____ D.D.S. Lic. # _____