



# Reliable Dental Laboratory

10610 Metric Dr. #190, Dallas Texas 75243  
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Texas Reg #2827




Date \_\_\_\_\_ Date Requested \_\_\_\_\_

Email: \_\_\_\_\_

Dr. \_\_\_\_\_

Patient: \_\_\_\_\_  Male  Female  Age \_\_\_\_\_

Abutment material choice: (please check box for the material of your choice for each tooth#)

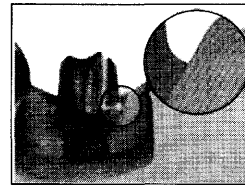
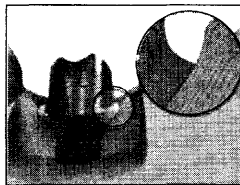
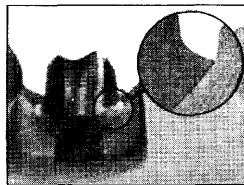
Tooth#	Implant brand	Platform $\emptyset$	  			Zir (four shades: 00, 10, 20, 30)
			Ti	GH	Zir	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shade# _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shade# _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shade# _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shade# _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shade# _____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shade# _____

### Emergence width options (select one)

Full anatomical dimensions

Contour soft tissue (default if no selection is made)

Support tissue



SPECIAL INSTRUCTION: \_\_\_\_\_

\_\_\_\_\_  
DENTIST'S SIGNATURE

\_\_\_\_\_  
LICENSE NO.