REC	DIS	PREP	PREPD	DIE	WAX	WAX	FIN	OP	B	G	POL	ETCH	DENTURE	SHIPPING

Pan #	Rec Date				
		☐ B	☐ M	☐ Part	☐ BP
		☐ CKB	☐ S/M	☐ Dent	☐ Art
		☐ I	☐ C/M	☐ BB	☐ Photo
		☐ O	☐ CRN/COP	☐ B/F	☐ ________

Case #	Inv #	

DENTAL LABORATORIES, INC.
470 Woodcreek Drive, Bolingbrook, IL 60440
(T) 630.679.8686 (F) 630.679.8680
30 North Michigan Avenue, Suite 1817
Chicago, Illinois 60602
www.artisticdl.com

Doctor ______________________________ Phone ____________________

Address ______________________________

City ____________________ ST __________ ZIP __________

Patient's Name ______________________________ Age __________ Male ___ Female ___

Delivery by 5 P.M. on

Shade ____________________

Please indicate Teeth involved:

Single Tooth #(s) ____________________

Splinted Tooth #(s) ____________________

Pontic Tooth #(s) ____________________

Notes:

Articulator

Net amount of invoice is due within 30 days of receipt of order. All balances beyond 30 days are subject to a 1 1/2% Finance Charge per month not to exceed 18% per year. I agree to pay reasonable attorney fees and collection costs if this account is referred to collection.

Doctor signature ______________________________ Lic. no. ______________

CERTIFIED DENTAL LABORATORY

FM 4.3-000-03