

Dentist _____ Invoice Name _____
 Invoice Address _____ Suburb _____ Postcode _____
 Tel _____ Email _____
 Patient ID _____ Date _____
 Patient ID - Please do not use patient's name unless consent is provided, and appropriate form/s have been completed.

BATCH # (Office only)

New Case Continuation/Remake Account Number
 Work Required by Day Month

- Wax-up ONLY Wax-up + Penn Stent (default)

SELECT PREFERRED SMILE TYPE

- Aggressive



- Dominant



- Enhanced



- Focused



- Functional



- Hollywood



- Mature



- Natural



- Oval



- Softened



- Vigorous



- Youthful



TURNAROUND TIME: 10 IN-LAB DAYS

(confirmed on receipt of order)

Teeth to wax-up _____

Existing tooth shade _____

Shade intended _____

Please allow wax-up thickness of up to 1.5mm for composite injection.

Please indicate your requirements:

Trim back model by _____ mm
 (if you plan to build the teeth out buccally less than 1.5mm, please specify how much)

No adjustment to the model
 (if require the teeth to be more buccally placed than pre-op position)

MATERIAL ENCLOSED

Please tick

	DR	SCD
Upper Impression	<input type="checkbox"/>	<input type="checkbox"/>
Lower Impression	<input type="checkbox"/>	<input type="checkbox"/>
Upper Model	<input type="checkbox"/>	<input type="checkbox"/>
Lower Model	<input type="checkbox"/>	<input type="checkbox"/>
Bite Registration	<input type="checkbox"/>	<input type="checkbox"/>
Images to be emailed	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL INSTRUCTIONS

PROMO CODE