LAB USE ONLY

CASE NUMBER

Send Date month/day/year

Due Date month/day/year

Appointment Time a.m. p.m.

☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Patient ______________________

Phone ______________ Age ____ Male ☐ Female ☐

Doctor ______________ Phone ____________

Address ______________________

City ______________ State ____ Zip ________

Please send: ☐ RX Forms ☐ Mailing Boxes ☐ Other: ________

SERVICES

Denture	upper	lower		upper	lower
☐ Custom Tray	☐	☐	☐ Reline	☐	☐
☐ Bite Rims	☐	☐	☐ Repair	☐	☐
☐ Wax Try-in with Teeth	☐	☐	☐ Rebase	☐	☐
☐ Process and Finish	☐	☐	☐ Essex	☐	☐
			☐ Bleach Trays	☐	☐
			☐ Retainer	☐	☐
			☐ Nightguard	☐	☐

○ Hard ○ Soft ○ Acrylic

Type of Teeth

- ☐ Bioform®
- ☐ Plastic Classic
- ☐ Ivoclar Blue Line
- ☐ Vita

Denture Base

- ☐ SR Ivocap® Injection (Premium)
- ☐ Select
- ☐ Economy

☐ Flipper	☐ upper ☐ lower
☐ Acrylic Partial	☐ upper ☐ lower
☐ Valplast Flexible Partial	☐ upper ☐ lower
☐ Metal Frame	☐ upper ☐ lower
○ Flexible Clasps	
☐ Duracetal Clasp	Shade ________

Please write, check, or circle each appropriate item. Use blue or black ink only
Retain the canary sheet foryour records, return white sheet with the work to be completed.

Omega Dental Lab

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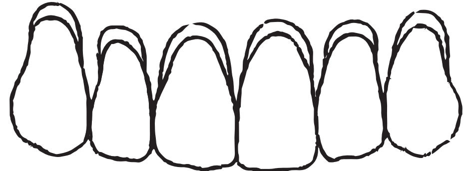
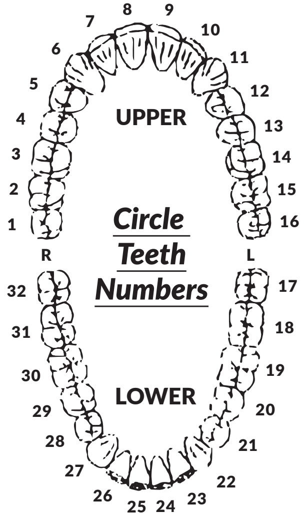
American Fork, UT 84003
(801) 692-1634
omegadentallabs@gmail.com

Removable Prosthetics

Shading and Characterizations



Shade ______



Finish: ☐ Reg. ☐ Characterized

Work Authorization Order

Date: ______________

Dr.'s Signature ______________________ **License #** __________

Terms: Due 10th of the month following delivery of work. Balance unpaid after this date is subject to a finance charge of 1 1/2 % per month. Purchaser agrees to pay reasonable attorney's fees and court costs in the event this account is placed in collection.