DENTAL LABORATORY WORK AUTHORIZATION

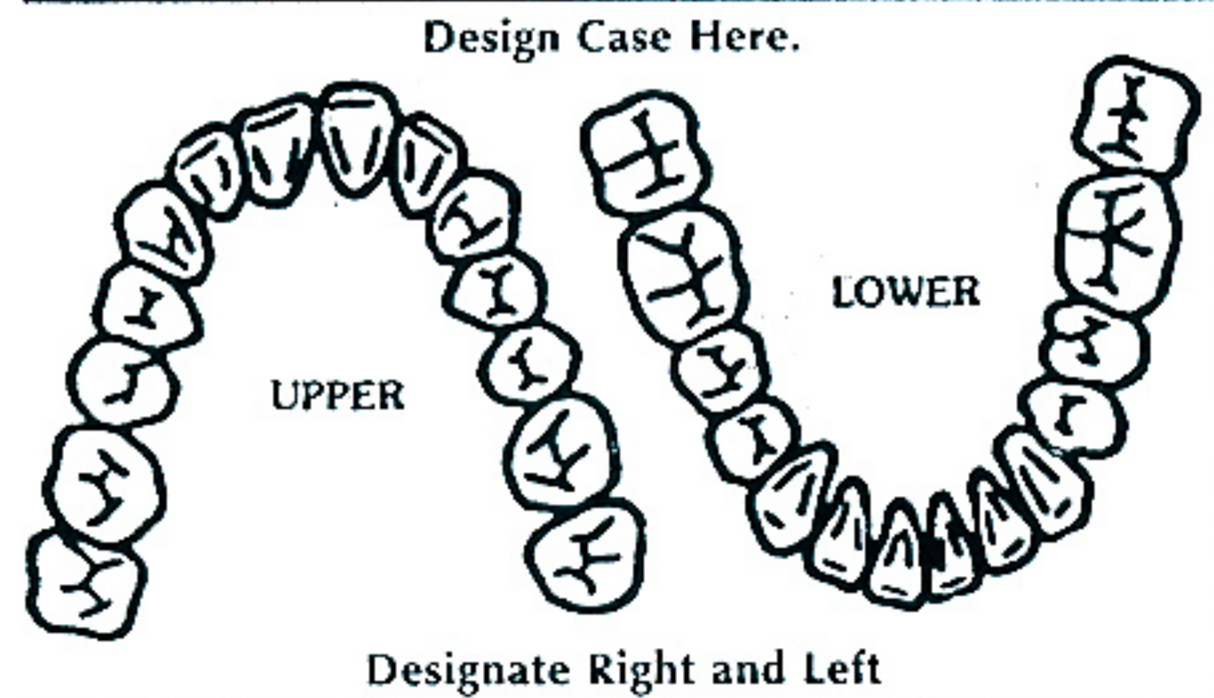
STATE OF OKLAHOMA

Date ______________________________

Name of Laboratory ______________________________

Address ______________________________

Design Case Here.




Designate Right and Left

Patient ______________
Type Restoration ______________
______________
Shade ______________
Mould ______________
Material ______________
______________
Date Wanted:
Try in ______________
Finish ______________

***Please print or write legibly and make instructions as complete as possible. Use reverse side if necessary.***

Signature ______________________________ D.M.D. D.D.S.

Address ______________________________

Dental License No. ______________________________

MUST BE RETAINED BY DENTAL LABORATORY FOR 3 YEARS

DENTAL LABORATORY WORK AUTHORIZATION

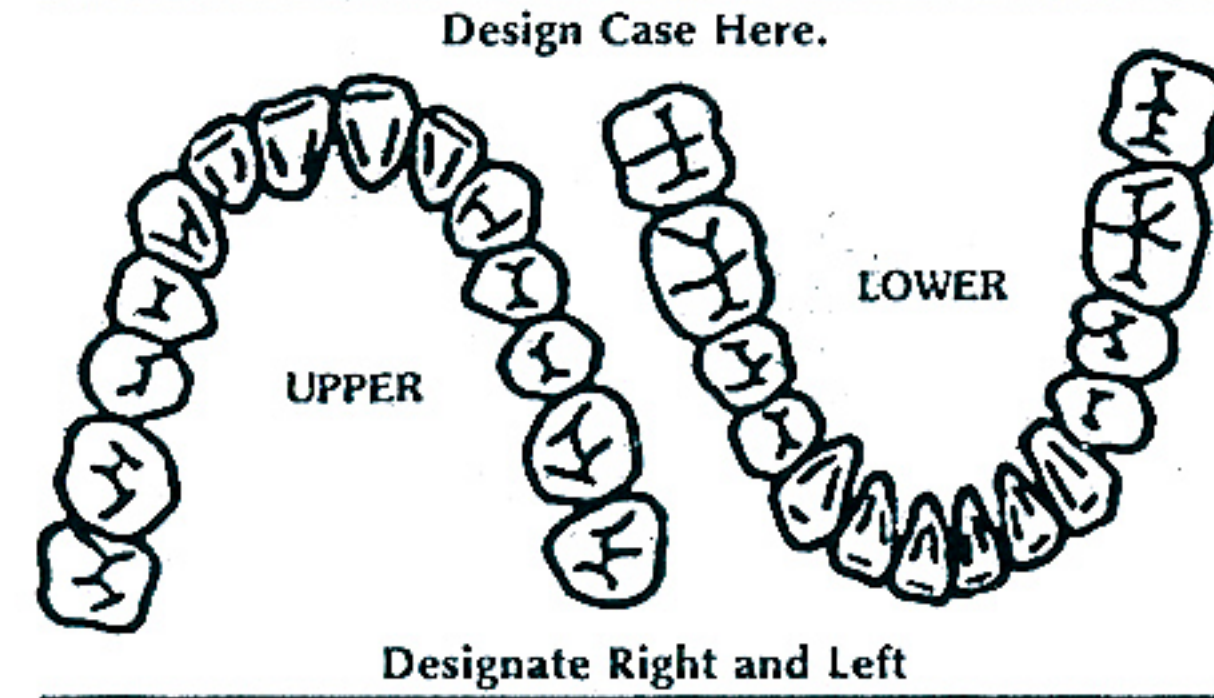
STATE OF OKLAHOMA

Date ______________________________

Name of Laboratory ______________________________

Address ______________________________

Design Case Here.

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