DUE DATE IN OFFICE: ____/____/____ BY 5 P.M. CALL IN ADVANCE IF EARLY DELIVERY IS NEEDED

Han S. Yang, C.D.T.

ART dental lab
FIXED · REMOVABLE · IMPLANTS

3852-A Dulles South Ct.
Chantilly, VA 20151
www.artdentallab.com
artdlab1@gmail.com

Toll Free: 1-866-645-7541
Local: 703-378-8555
Fax: 703-378-4555

Date: / /

Dr.

Address

Phone: Fax:

Patient Information: □ Female □ Male Age: ____

Name:

Office Use Only

Date:								
Initials:								

RESTORATION TYPE / MATERIAL

Teeth # ____________________

□ **Crown** □ **Bridge**

ALL-CERAMIC

□ ZirconiART □ e.maxZir □ Full Zirconia
□ e.max Press □ e.max Mono □ ________

PORCELAIN TO METAL

□ Hi Noble □ Semiprecious □ Non-Precious

FULL METAL CROWN

□ Yellow Gold □ White Gold □ Non-Precious

MODIFICATIONS

□ Framework Try-In □ Facial Porcelain
□ Porcelain Butt Margin □ Lingual Zirconia
Other: ____________________

□ **Implant Abutment**

□ Cement Retained □ Screw Retained
□ Titanium with Warranty □ Full Zirconia
□ Titanium Abutment □ ZirconiArt
□ Zirconia Abutment □ BioHPP Lingual Screw
□ Gold UCLA

□ **Veneer**

□ e.max Press □ Non-Prep Veneer

□ **Inlay** □ **Onlay**

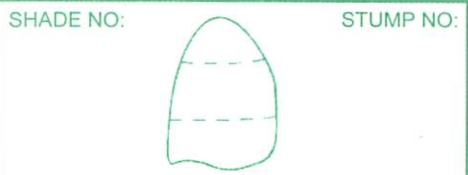
□ e.max □ Indirect Composite □ Yellow Gold □ White Gold

□ **Post & Core**

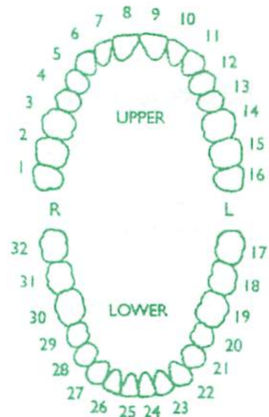
□ Yellow Gold □ White Gold □ Zirconia □ e.max

□ Provisional Shell □ Diagnostic Wax-Up

SHADE INFORMATION



□ Call me! I would like to speak with ____________



Signature ____________________ License # ____________________

I agree to pay full remittance of charges incurred by this prescription within thirty (30) days of statement. I further agree to pay all costs incurred in collection should I default, including without limitation, reasonable attorney's fees and a monthly service charge of 2.5% of outstanding balance.