# OCCLUSIONS

**Dental Laboratory, Inc.**
**287 Appleton Professional Building**
**Lowell, MA 01852**
**Tel: (978) 323-0446**

Patient: ____________________

Doctor: ____________________ Sex: ☐ Male ☐ Female Age: ________

| Today's Date | **Return Date** | Tooth Shade: ☐ |
|---|---|---|
| ____/____/____ | ____/____/____ | Ant. Mould: ________ |
| | Pt. Appt ________ | Post. Mould: ________ |

| S T A N D A R D – P R E M I U M – C H A R A C T E R I Z E D | | |
|---|---|---|
| ☐ Custom Tray | ☐ Set-up | ☐ Guard - Hard Clear<br>Max or Mand |
| ☐ Baseplate/Biteblock | ☐ Process/Finish | ☐ Repair |
| ☐ Cast Partial | ☐ Immediate Set-up & Finish | ☐ Reline<br>☐ Hard<br>☐ Soft |
| ☐ Flexible Partial | ☐ Flipper (1-2 Tooth) | |
| ☐ IMPLANT/ATTACHMENT | | Patient ID: Yes No |

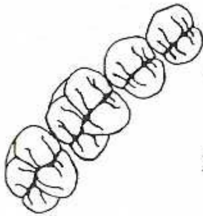
Upper

Lower

Special Instructions: ____________________

Dentist's Signature: ____________________ License #: ________

DELUXE FOR BUSINESS 1-800-888-6327 Ref. No: G 163300242



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