SHAW Lab Group

DATE SENT _____

PATIENT'S NAME _____

AGE _____ GENDER ☐ M ☐ F ☐ X

NEXT APPOINTMENT DATE _____

DATE/TIME REQUIRED _____ AM/PM

☐ **PHONE ME CONCERNING THIS CASE**

DOCTOR _____ E-MAIL _____

PRACTICE NAME _____ TELEPHONE _____

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

**Scan to view the digital version of our latest Product and Fee Guide**

## C&B

☐ **Implant**

**Zirconia**
- ☐ Full Contour Monolithic
- ☐ Translucent Aesthetic
- ☐ Porcelain Layered

**e.max**
- ☐ Monolithic
- ☐ Layered

**PFM**
- ☐ Non-Precious
- ☐ Semi-Precious
- ☐ Precious

**Full Metal**
- ☐ Non-Precious
- ☐ White Gold
- ☐ Yellow Gold

☐ **Surgical Guide**

Provide details below

## Orthodontics

☐ **Upper** ☐ **Lower**

**Nightguards**
- ☐ Thermoplastic
- ☐ Hard
- ☐ Extra Hard
- ☐ Hypoallergenic
- ☐ Daytime (Slim)

- ☐ **Snoring & Sleep**
- ☐ **Other Splint**
- ☐ **Space Maintainer**
- ☐ **Retainer**
- ☐ **Other Appliance**
- ☐ **Trays**
- ☐ **Aligner**

**Appliance Insurance** ☐ 1 Year ☐ 2 Years

Provide details below

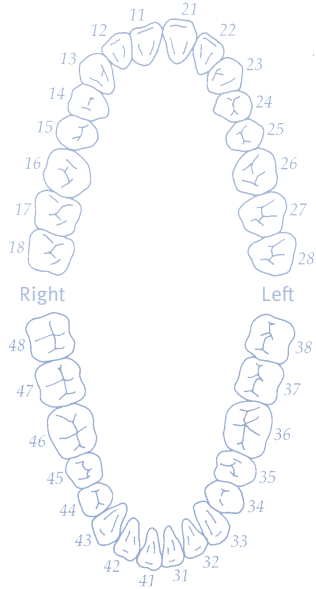
## Dentures

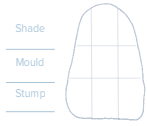
☐ **Try-in** ☐ **Finish**

- ☐ Complete Denture
- ☐ Immediate Denture
- ☐ Copy Denture
- ☐ Acrylic Partial
- ☐ Flexible Partial
- ☐ Metal Frame
- ☐ Overdenture
- ☐ Implant Hybrid
- ☐ Bite Block
- ☐ Custom Tray
- ☐ Repair
- ☐ Reline
- ☐ Rebase

Provide details below

DETAILED INSTRUCTIONS




DOCTOR'S SIGNATURE: _____

TOP - LABORATORY COPY

BOTTOM - DOCTOR'S COPY

No Fit, No Fuss PROMISE