



Hi-Tech Dental Lab
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 Tel: (713)977-4594



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PRESCRIPTION

IMPORTANT CHECK LIST

- DUE DATE
- BITE REGISTRATIN
- OPPOSING MODEL
- SHADE
- CASE DISINFECTED YES NO
- TIME

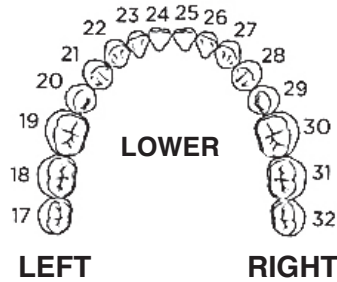
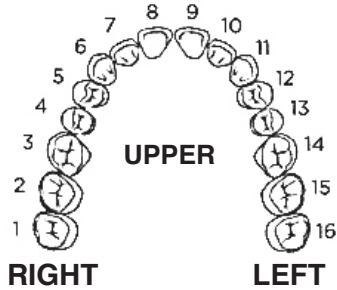


DOCTOR NAME _____

PATIENT NAME _____

DUE DATE _____ TRY IN _____ FINISH _____ AGE _____

- MALE
- FEMALE



SHADE NO. _____

FULL CAST

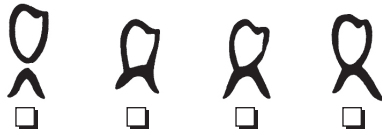
- High Noble
- Noble Yellow
- Noble White
- Predomianty Base

CERAMICS

- High Noble
- Noble
- Predomianty Base

PONITIC DESIGN

PONTICS



SIGNATURE _____

SHADE NO. _____

DATE _____ LICENCE NO. _____

CASE # _____ PAN # _____

- SEND MORE**
- RX's
 - Labels
 - Boxes

Net amount of invoices is due with 30 days of receipt of order: all balances beyond 30 days are subject to a finance charge of 1.5% I agree to pay reasonable attorneys fees and collection coast if this account is referred for collection.

WHITE COPY FOR LAB YELLOW COPY FOR DOCTOR