PEEBLES PROSTHETICS, INC.

RETURN DATE ________________ **TIME** _______ **A.M.** _____ **P.M.**

DOCTOR INFORMATION: License # ________________

Name: ____

Address: ____

Phone Number: _____________________________________

PATIENT INFORMATION

Name: ____

Sex: __________ Age: __________

☐ PFM	☐ Implant	☐ Reline	☐ Hawley
☐ Full Cast Crown	☐ Complete Denture	☐ Repair	☐ SPC. Maint.
☐ E-max	☐ RPD / Framework	☐ Custom Tray	☐ Splint
☐ Zirconia	☐ Flipper / Acrylic Partial	☐ Base Plate	
☐ Diagnostic Wax-Up	☐ Flex Partial	☐ Other ________________	

SHADE: __________ PREP SHADE: __________ MOULD: _________

☐ High Noble ☐ Noble ☐ Base

INSTRUCTIONS:

Signature Below Indicates Acceptance of Full Responsibility for Payment

____

Authorized Signature Date

White copy to Peebles Prosthetics, Inc / Yellow copy for Dentist Office

909 Wadsworth Blvd., Lakewood, CO 80214 (303) 462-3744 fax: (303) 462-3737