Dental Laboratory Work Authorization

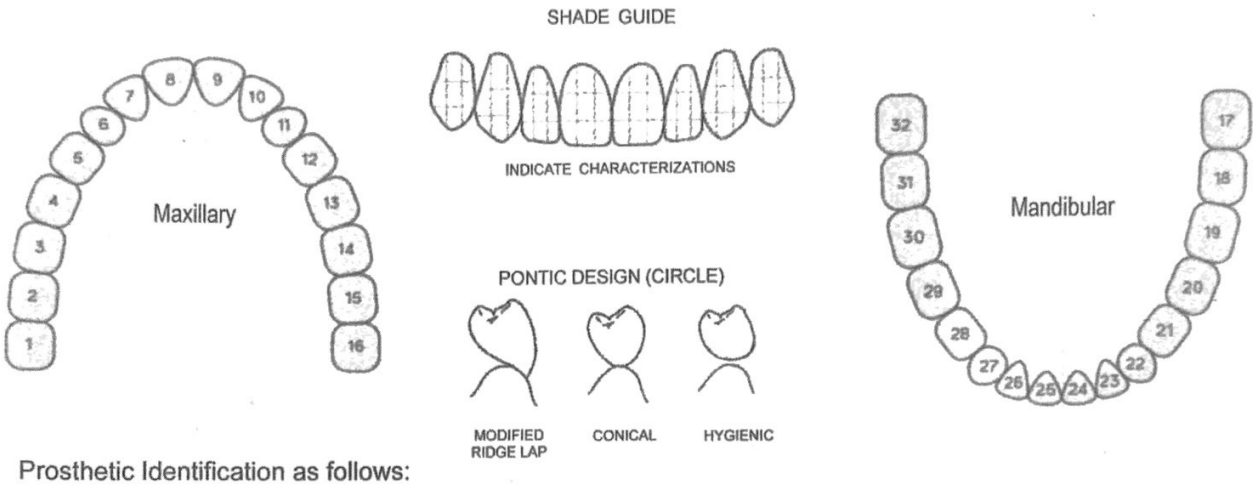
Patient's name _____ Date: _____

SK Dental Arts, LLC
3619 Gail Drive
Imperial, MO 63052
636-287-1340

Practice name _____

Practice address _____

Material _____ Type of restoration _____



Prosthetic Identification as follows:

Name _____ SSN _____ Other _____

Teeth, Facings or Pontics				
Location	Material	Shade	Guide	Mold
Max Ant				
Max Post				
Man Ant				
Man Post				

Return Date _____

Try In Date _____

Finish Date _____

INSTRUCTIONS

Case has been disinfected - ❑ yes ❑ no

DOCTOR'S SIGNATURE _____ DDS/DMD LICENSE# _____ DATE _____

A copy of this form must be retained in the dental laboratory office and the dentist's office for a period of 2 years.