

DENTIST'S NAME: _____

PATIENT: _____

TODAY'S DATE: _____

DATE REQUIRED

RESTORATION TYPE _____ TOOTH POSITION _____

MAIN SHADE _____ CERVICAL SHADE _____

SHADE OF ADJACENT TEETH _____ TOOTH SURFACE High Gloss

ITEMS SUPPLIED BY DENTIST _____ Med Gloss

ITEMS SUPPLIED BY LAB _____ Matt

STERILISED Yes No



NOTES:

