NAVATRA SOLUTIONS

DENTAL LABORATORY

Phone: 562-353-3174
Email: admin@navatrasolutions.com

Today's Date: _____

Dentist: _____

Office Name: _____

Office #: _____

Delivery Address:

_____

_____

Case Due: [ ]

Patient Name/Case Identifier: _____

NIGHT GUARDS

- ◯ Upper
- ◯ Lower
- ◯ Molar to Molar
- ◯ Bicuspid to Bicuspid
- ◯ Astron
- ◯ Hard
- ◯ Soft

Name on Night Guard: _____

(Optional)

FULL CONTOURS

- ◯ Crowns
- ◯ Bridges
- ◯ Veneers
- ◯ Inlay/Onlay

ESSIX RETAINERS

- ◯ 0.75mm
- ◯ 1.0mm
- ◯ 1.5mm

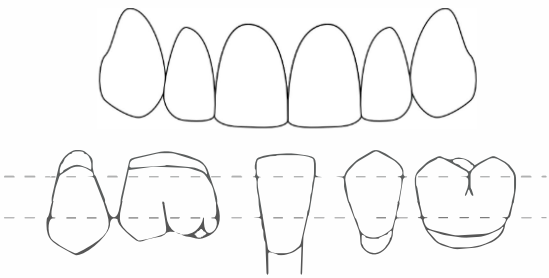
BLEACHING TRAYS

- ◯ Upper
- ◯ Lower

Teeth#:

Shade:

Special Instructions:



Please indicate if distribution of hues or special characteristics are desired.

Dentist Signature : _____

(Required)

TERM: Net 25 days. A 2% late fee is applied to invoices past 25 days.