



# Sofia Dental Studio

1150 N. Country Club Dr., #5

Mesa Az 85201

Phone/Fax (480) 969 7537

Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

City/State: \_\_\_\_\_

Patient: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Date Sent: \_\_\_\_\_ Date Wanted: \_\_\_\_\_

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16		
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Left
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17		

☐ Impression  
☐ Master Model  
☐ Opp. Model  
☐ Bite  
☐ Photo  
☐ Other \_\_\_\_\_

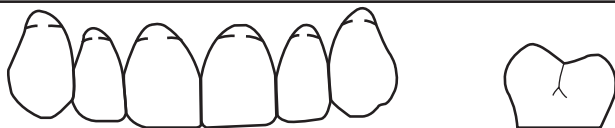
	Precious	Semi-Precious	Non-Precious
Porc. Fused to Metal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Porc. Butt. Margin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Porc./Met. Occlusal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Full Cast Crown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inlay/Onlay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All Porcelain Restoration	Crown	Veneer	Inlay/Onlay
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Full Lap 	Buccal Lap 	Sanitary Contact 	Sanitary Spaced 
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Shade _____	Occlusal	<input type="checkbox"/> None	<input type="checkbox"/> Medium
Prep Shade _____	Stain	<input type="checkbox"/> Light	<input type="checkbox"/> Dark

## Instructions:



Signed \_\_\_\_\_

Dentist's License Number \_\_\_\_\_ Date \_\_\_\_\_

All accounts are due within 30 days of statement date. A service charge of 2% per month or 24% annual will be added to past due accounts.

Person signing this authorization accepts sole responsibility for payment, and agrees to pay all legal costs in the event of suit, including reasonable attorney fees.