LABORATORY COPY

NAME: D.D.S.

ADDRESS: PHONE:

CITY:

VIKING DENTAL LAB

(517) 512-0051
1300 N. WAVERLY RD.
SUITE #1
LANSING, MI 48917

DATE: LAB CASE NO:

PATIENT'S NAME:

PATIENT'S NUMBER: AGE:

SEX:

FINISH: APPT DATE:

ZIRCONIA **SHADE**

TYPE AND DESCRIPTION OF CASE
PLEASE GIVE COMPLETE INSTRUCTIONS

INSTRUCTIONS

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DENTIST'S SIGNATURE _____ D.D.S.