

Castle

Dental Laboratory

Removable Prosthetics

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 Daly City, CA 94014
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WORK ORDER

Today's Date _____

Dr.: _____ Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Due Date: _____ Time: _____ AM PM

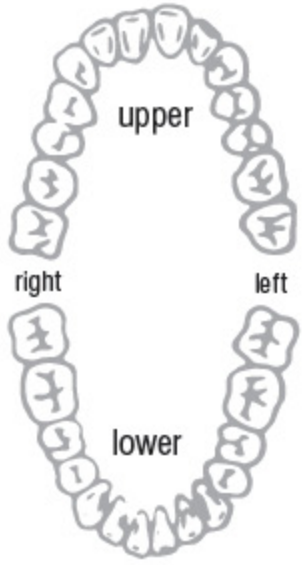
Please check requested service(s) for next appointment:

- | | | |
|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Custom tray | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Occlusal rims/bite | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Wax try-in with teeth | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Process & finish | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Vitallium® framework only | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Vitallium® framework with bite | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Denture ID – print information desired: _____ | | |

Shade: _____ Plastic Porcelain

Mould: Upper Anterior _____ Posterior _____ Lab to select
 Lower Anterior _____ Posterior _____ Lab to select

INSTRUCTIONS



 Personal Signature of Dentist

 License #