TEL: (647) 401-8089
E-MAIL: INFO@DENTURECRAFTERS.CA
WWW.DENTURECRAFTERS.CA

Case Number:	
Date Sent to the Lab:	
Date Expected from Lab*:	
**day before appointment*	

Doctor:		**Patient**'s Gender: ☐ M ☐ F
		First Name:
Address:		Last Name:
		Age: Shade:
Tel:		☐ Frame Try-In
☐ Please call us before proceding with the case.		☐ Try-In ☐ Finish

Additional Instructions:

Professional's Signature: