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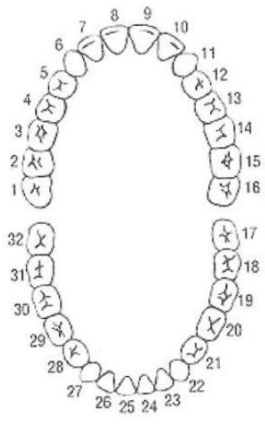
TODAY'S DATE	DATE REQ.
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DOCTOR: _____ PHONE: _____

Street Address _____ City _____ State _____ Zip _____

PATIENT: _____ M F

	SHADE	STUMP
	<input type="checkbox"/> Sanitary <input type="checkbox"/> Bullet <input type="checkbox"/> Modified Ridge Cap	<input type="checkbox"/> Full Ridge Cap <input type="checkbox"/> Ovate



ALL CERAMIC	<input type="checkbox"/> E-max®	<input type="checkbox"/> Full Zirconia	<input type="checkbox"/> Layered Zirconia
PORCELAIN FUSED TO METAL	<input type="checkbox"/> Non-precious	<input type="checkbox"/> Semi-precious	<input type="checkbox"/> High Noble
FULL CAST	<input type="checkbox"/> Crown	<input type="checkbox"/> Inlay/ Onlay	<input type="checkbox"/> Post Core
	<input type="checkbox"/> Gold	<input type="checkbox"/> Semi-precious	<input type="checkbox"/> Non-precious
REMOVABLE APPLIANCES	<input type="checkbox"/> Denture	<input type="checkbox"/> Cast Partial	<input type="checkbox"/> Valplast
	<input type="checkbox"/> Custom Tray	<input type="checkbox"/> Bite Block	<input type="checkbox"/> Set Up
	<input type="checkbox"/> Reline		
NIGHTGUARD	<input type="checkbox"/> Dual	<input type="checkbox"/> Soft	<input type="checkbox"/> Hard
		BLEACHING TRAY	<input type="checkbox"/>
DIAGNOSTIC WAX -UP	<input type="checkbox"/>		

Authorized Signature: _____ License # _____

Person signing this authorization accept responsibility for payments and agrees to pay all legal cost. In the event of suit including reasonable attorney fees.