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Doctor's Name: _____ Patient's Name: _____
Address _____ Age _____ Female _____ Male _____
Phone # _____ Acct # _____ Deliver by 5 p.m. on _____ Review Time: _____
Email Address _____

Enclosed with case:
Impressions Models Bite Photos Other: _____

Denture

- Ivoclar DCL Denture
- Custom Tray
- CAD/CAM Denture
- Occlusion Rim
- Immediate Denture
- Wax setup try-in
- Finish

Removable Partial Dentures

- SLA metal frame
- Frame try-in
- Valplast
- Frame w/occlus. Rim
- Flipper
- Frame w/setup try-in
- Ultaire AKP
- Finish

Splints/Nightguards

- Hard
- Soft
- Hard & Soft

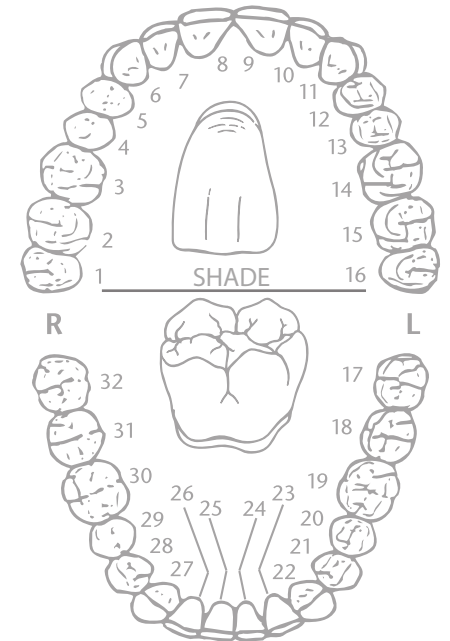
Repair

- Reline
- Add Clasp
- Breaks/Cracks
- Add Tooth
- Add Retention

Minor Connector

Maxillary	Mandibular	Clasp Options	Tooth #
<input type="checkbox"/> Lab Select	<input type="checkbox"/> Lab Select	<input type="checkbox"/> Lab Select	_____
_____	_____	<input type="checkbox"/> Metal	_____
Rest Areas	Tooth #	<input type="checkbox"/> EsthetiClasp	_____
<input type="checkbox"/> Lab Select	<input type="checkbox"/> Lab Select	<input type="checkbox"/> Thermoflex	_____
_____	_____		_____

Additional Notes



Doctor's Name: _____ Signature _____ License #: _____