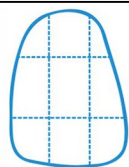


Dentist/Clinic/Address/Tel										Date of order	
										Order number	
										Color	
											
Patient name										Personal number	
										<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Select type of work	MK CoCr	MK Gold	Post CoCr	Post Gold	Full Crown	Inlay	Combined Work	Maryland Bridge	All ceramic		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Full Zirconia	Zirconia	E-Max
	impl. Cast	impl. Titanium	Composite	Denture	Partial Denture	CoCr frame	Night Guard	Reparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	impl. Milled	impl. cem.	Acrylic	Valplast	<input type="checkbox"/>	Temporary	W. clasp	<input type="checkbox"/>	Test date		
Implant System :											
Instruction											
										Fully finished	