**STOMADENT**
FULL SERVICE DENTAL LAB

503 SW 5th Ave.
Meridian, ID 83642
208-888-1927

Doctor: *
Office Name: *
Street: *
City: * Ph: *

**Teeth Selection**
- Econ
- Basic
- Premium
- Signature

**Vital Information**
- RX Date: *
- Due Date: *
- AM: PM:
- Patient Name: *

**INSTRUCTIONS**
- Call Doctor
- Try-In
- Process
- View Only

**Teeth Selection**
- Mold
- Shade *

**Personality**
- Soft
- Medium
- Vigorous

**Face Shape**
- Oval
- Taper
- Square
- Rectangular

**INSTRUCTIONS**
- Try-In
- Process
- View Only

**Type of Restoration**

**Partials**
- Milled Titanium
- Cast Metal
- Valplast
- Milled Acetal Resin
- Acrylic Base

**Dentures**
- Full Denture
- Immediate Denture
- Milled Denture
- Printed Denture

**Other**
- Repair
- Reline
- Nightguard (soft___ hard ____)
- Flipper

***ALL CONTACT INFO IS REQUIRED***

Send more:
- Lab Slips
- Mail Labels
- Boxes

Dr. Signature *
License No.*