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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

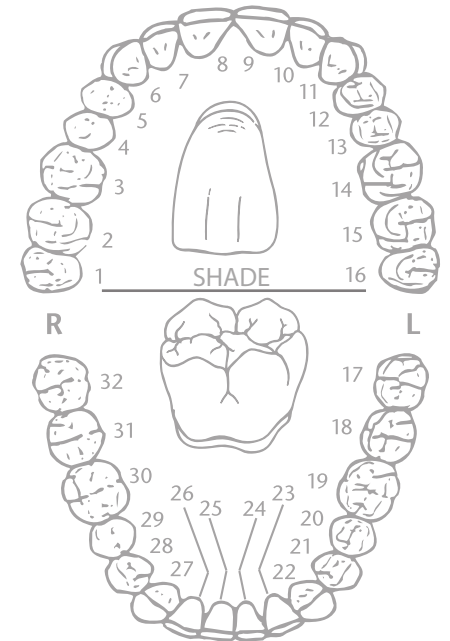
**Repair**

- 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	_____
<b>Rest Areas</b>	<b>Tooth #</b>	<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 #: \_\_\_\_\_