MISSOURI DENTAL BOARD
DENTAL LABORATORY WORK AUTHORIZATION

Patient's name _____ Date _____

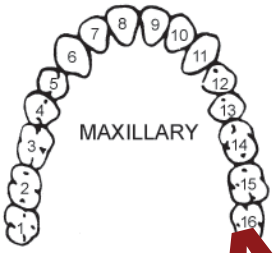
Dentist's name _____ Laboratory name _____

Dentist's address _____ Laboratory address _____

City, state, zip _____ City, state, zip _____

Material _____ Type of restoration _____

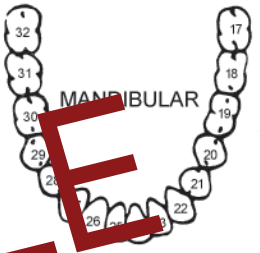
SHADE GUIDE



INDICATE CHARACTERIZATIONS

PONTIC DESIGN (CIRCLE)

MO... RID... ...ONAL ...HYGIENIC



Prosthetic id...tification ...f ...: Name _____ SSN _____ Other _____

Teeth Facings or Pontics				
Location	Material	Shade	Guide	Mold
Max Ant				
Max Post				
Man Ant				
Man Post				

Return Date _____

Try in Date _____

Finish Date _____

INSTRUCTIONS

DOCTOR'S SIGNATURE _____ DDS/DMD LICENSE # _____ DATE _____

Dentists: If interested, please request point of origination of dental restoration and/or materials.

A copy of this form must be retained in the dental laboratory office and the dentists' office for a period of 7 years (for minors 7 years after age of 18).