

# Ohio State Dental Board Laboratory Prescription & Point of Origin Form

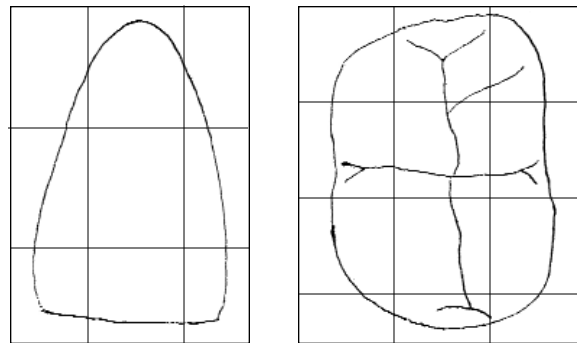
Today's Date	Try-In Date	Finish Date
Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female    Age	
Type of Restoration		
Dentist Name	Signature	
DDS/DMD License #	Phone	
Dentist Address	City/State/Zip	
Lab Name	Phone	
Lab Address	City/State/Zip	

## **TYPE OF RESTORATION**

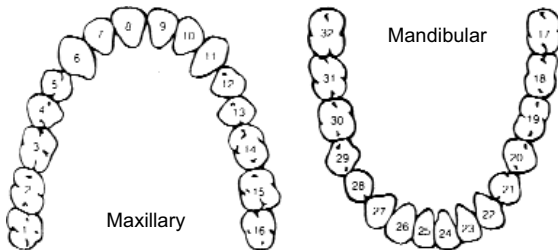
- |  |   |
|--|---|
| <input type="checkbox"/> Porcelain to High Noble<br><input type="checkbox"/> Porcelain to Noble<br><input type="checkbox"/> Porcelain to Base Metal (NP)<br><input type="checkbox"/> Full Metal High Noble<br><input type="checkbox"/> Full Metal Noble<br><input type="checkbox"/> Full Metal Base (NP)<br><br><input type="checkbox"/> Max Full Denture<br><input type="checkbox"/> Mand Full Denture<br><input type="checkbox"/> Max Partial Denture<br><input type="checkbox"/> Mand Partial Denture | <input type="checkbox"/> All Ceramic (specify) _____<br><br><input type="checkbox"/> All Composite (specify) _____<br><br><input type="checkbox"/> Other (specify) _____<br><br><b>Pontic Design</b> (circle) |
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## **CUSTOM SHADING**



## **PARTIAL**



## **INSTRUCTIONS**

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## **SHADING**

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## **DENTAL RESTORATION POINT OF ORIGATION FORM**

*Attention Lab: Complete this section and return to doctor when case is received.*

Doctor Name	Patient Name
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This case will be:  Fabricated by technicians at our own dental laboratory.

Sent to another laboratory in the U.S. to be fabricated:

Lab Name	Location
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Sent to an overseas/foreign laboratory to be fabricated:

Lab Name	Location
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Materials to be used in fabrication: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

