

LAB CARD

Patient Name: _____

Patient D.OB.: _____

Tooth shade: _____

Doctor Name: _____

Doctor Address: _____

Doctor Phone #: _____

Doctor License #: _____

Doctor E-Mail: _____

•Please provide 3-D rendering work-up for the following treatment:

- Upper NeXsmile™
- Lower NeXsmile™
- Segmental Care-Area(s) to study: _____



Checklist For Items In Return Package:

- Lab Card
- CT-BYTE
- DI-COM CD
- Upper/Lower Impressions