

LABOSmileUSA

Dental Lab

1300 SW 10th Street, Suite 1
 Delray Beach FL 33444
 Phone Number: (561) 330-4635
 Fax: (561) 330-9314
 Email: info@labosmileusa.com

RX Date: _____

Deliver by: _____

Patient Appointment: _____

Patient Name: _____

Male Female Approx. Age: _____

TEETH NUMBERS															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- | | |
|--|--|
| PORCELAIN FUSED TO METAL:
<input type="checkbox"/> PORCELAIN TO NON-PRECIOUS
<input type="checkbox"/> PORCELAIN TO SEMI PRECIOUS
<input type="checkbox"/> PORCELAIN TO WHITE HIGH NOBLE
<input type="checkbox"/> CAPTEK | ALL CERAMIC:
<input type="checkbox"/> EMAX
<input type="checkbox"/> LAYERED ZIRCONIA
<input type="checkbox"/> FULL ZIRCONIA
<input type="checkbox"/> HIGH TRANS FULL ZIRCONIA |
| FULL CAST:
<input type="checkbox"/> NON-PRECIOUS (WHITE)
<input type="checkbox"/> NON-PRECIOUS (YELLOW)
<input type="checkbox"/> POST & CORE NON-PRECIOUS
<input type="checkbox"/> POST & CORE SEMI PRECIOUS | IMMEDIATE DENTURES & PARTIALS (ONE ST)
<input type="checkbox"/> VALPLAST
<input type="checkbox"/> FLIPPER
<input type="checkbox"/> ACYLIC PARTIAL
<input type="checkbox"/> DENTURE |
| MARGIN DESIGN:
<input type="checkbox"/> LINGUAL METAL COLLAR
<input type="checkbox"/> 360 DEGREE METAL COLLAR
<input type="checkbox"/> NO METAL COLLAR
<input type="checkbox"/> METAL LINGUAL | <input type="checkbox"/> CROWN
<input type="checkbox"/> BRIDGE
<input type="checkbox"/> SPLINTERED
<input type="checkbox"/> VENEER
<input type="checkbox"/> INLAY/ONLAY
<input type="checkbox"/> WING |
| | OTHERS:
<input type="checkbox"/> HARD NIGHT GUARD/SOFT LINING
<input type="checkbox"/> BLEACHING TRAY
<input type="checkbox"/> RETAINER |

Doctor Name: _____

Address: _____

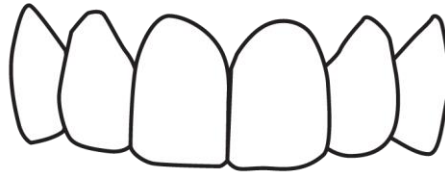
City/State/Zip: _____

Phone Number: _____

Other Instructions (Print Neatly, No Cursive)

Shade Details

Shade: _____



Metal Design



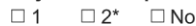
Embrasure:



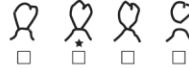
Proximal Contact:



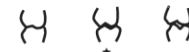
Layer of Die Spacer:



Pontic Design:



Occlusal Contact



TERMS & POLICY

By signing or sending this RX slip (or a substitute therefor) to Labosmile USA, I agree to abide by all the following terms and policies. Labosmile USA is not liable for incidental or consequential damages. Including inconvenience, lost wages, chair time, or pain and suffering.

All statements must be paid in full by the 15th of the month in which the statement is prepared. Any amount not paid will incur a 1.5% finance charge and the account will be placed on C.O.D. terms. All cases will be billed and payable in stages. \$50.00 will be charge on all returned checks. All disputes shall be governed by Florida law with venue in Palm Beach County with the prevailing party to recover all fees and expenses associated with case.

WHAT IS COVERED?

- Repair or replacement of appliance

WHAT IS NOT COVERED?

- Cash refund for prosthesis
- Cost incurred for removal or insertion
- Repairs resulting from accidents, neglect, abuse, failure of supportive tissue structures, improper adjustments, or improper dental hygiene.
- incidental or consequential damage, including inconvenience, lost wages, chair time, or pain and suffering.
- Labosmile USA LLC. is not liable for any fixed prosthetic (over 5 units) or any removal prosthetic, that has not be appropriately fitted prior to process
- Repairs, relines, immediate dentures, immediate partials and appliances partially fabricated or completely fabricated by another lab than Labosmile USA, LLC.

CONDITIONS OF WARRANTY

- Prosthesis must be inserted by a licensed practicing dentist.
- Patient must adhere to semi-annual dental maintenance (cleaning and exam) Program, in the office of a licensed practicing dentist.
- Dental prosthetic must be returned with model work for credit to be issued

Warranty is for 3 years from delivery date. this warranty is in lieu of all other warranties, whether expressed or implied and may not be may modified by any agent, employee, representative, or distributor of Labosmile USA, LLC

Signature: _____

Dr. License Number: _____