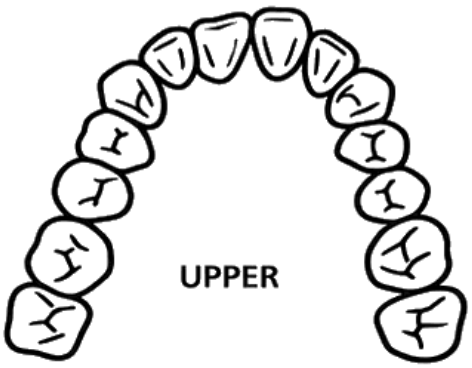
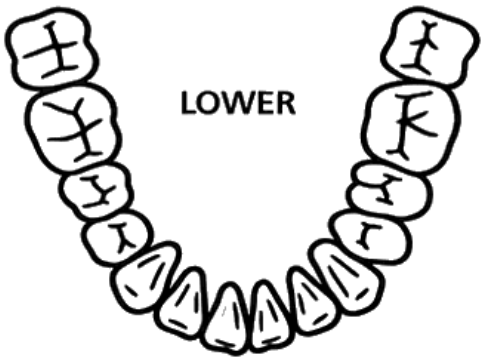
GOOD YEAR Dental Laboratories Canada Ltd.

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Telephone: 604-873-1613
Email: goodyeardental@outlook.com

Doctor _____ Date _____

Patient _____ Date Req'd _____





IF PATIENT WANTS TO COPY THE OLD DENTURE, PLEASE PROVIDE PICTURES OR MODELS OF THE OLD DENTURE AT THE TIME OF FIRST PRESCRIPTION. OTHERWISE ADDITIONAL COSTS WILL INCUR.

Rx _____

_____

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PLEASE INDICATE CASE REQUIREMENTS BELOW

SHADE



A	METAL	☐ GOLD	☐ SEMI-PREC (NOBLE)		
B	OCCLUSION	☐ METAL	☐ PORCELAIN	☐ ZIRCONIA	
C	LABIAL MARGIN	☐ FINE METAL COLLAR	☐ PORCELAIN TO MARGIN	☐ PORCELAIN BUTT MARGIN	
D	ZIRCONIA	☐ CRYSTAL	☐ FULL		

E	PONTIC DESIGN	1. HARMONY	2. CONE	3. HYGENIC	4. RIDGELAP
		 ☐	 ☐	 ☐	 ☐