ORIODENT
IMPLANT
LABORATORY

Oriodentimplant@gmail.com **07832906042**

118 Cressingham Road, Edgware, London, HA8 0RR

ENCLOSURES	
Models	
Upper	Lower
Impressions	
Upper	Lower
Bite Reg.	
Face Bow	
Other	
Code	

Prescribing Dentist: _____

Surgery Address: _____

Patient Name: _____

Date Required: _____

(Please allow 2 working days before appointment)

Tooth Notation:

SHADE:

ADDITIONAL NOTES:

DENTIST SIGNATURE:

Please ensure correct instructions and all enclosures have been disinfected

*This custom made Dental Appliance has been manufactured for the patient listed above.
Please record any modifications to original prescription and initial. **This appliance is supplied in a NON_STERILE form**.
*Please note all accounts beyond our credit terms will be passed to our debt collection agency, Sinclair Goldberg Price Ltd. All accounts, without exception, will be subject to a surcharge of 15% plus VAT to cover our costs in recovery. These accounts will also be subject to any legal costs incurred in obtaining settlement.

Approved for release by: *Office use only* Date: *Office use only*