

Lab order form

Attending Doctor: _____

Patient Information

First Name: _____

Last Name: _____

Treatment Options

Both arches

Upper arch

Lower Arch

Comments:

Please ALWAYS transmit the following patient data:

1. X-Ray *
2. Clinical Photos *
3. Impressions

* please make use of our portal
www.klineportal.de

Date

Signature

Stamp

