



Office: (775) 827-6645
 Fax: (775) 827-6650

5420 Kietzke Ln, Ste 205
 Reno, NV 89511
 www.n-sequence.com

For Office Use Only

Ship by: _____
 Shipping In _____

Removable RX

RX Date: _____

Due Date: (required) By Noon
 See back for lab times By 5pm

Incomplete Lab slip will delay your case

Dentist Name _____ Phone # _____

Patient LAST NAME, FIRST NAME Age Gender

TEETH

- PLASTIC
- COMPOSITE
- PORCELAIN
- OTHER: _____

MOLD:

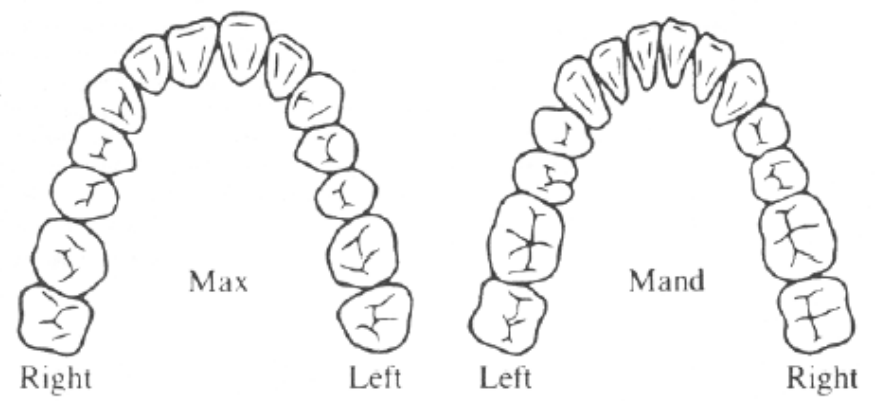
SHADE:

E-mail Pictures to: office@sequencedental.com

Special Instructions:

Call Doctor*
 *Allow 2 more days

Dentist Signature _____ Lic # _____



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

Ship To:

Practice _____
 Address _____
 City _____ State _____ Zip _____

Payment Method: Visa MasterCard Amer. Express *Invoice
 *New Clients will be billed by credit card unless credit application has been completed

Card # _____ Exp Date _____
 Signature _____ Print Name _____

