

LABORATORY PRESCRIPTION



MILFORD·MASON
DENTAL TECHNOLOGY
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Prescribing Dentist & Address

Date received in Lab
Case No.

Patient Name

Date required * (not appointment date)
Metal Try-In _____ Biscuit Try- In _____
Finish _____
* please allow **10 working days** in Laboratory
unless prior arrangement has been made

Age: _____
Male: _____ Female: _____

Type of Restoration:

Instructions & Patients Requirements (continue over)

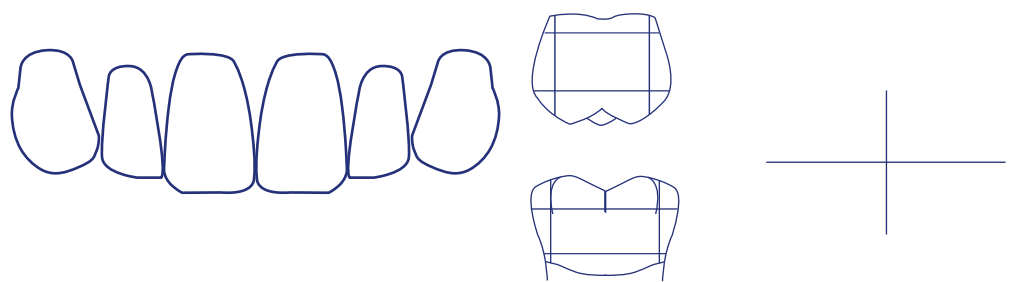
PFM precious
non precious
Zirconia
Emax
Gold
Other

IMPLANT
System
Size
Screw retained
Cement retained

Enclosed:
Silicone U/L
Opposing U/L
Study models
Bite record
Other

Photo / email

DISINFECTED? Y / N



Shade

Notation

Case reviewed & accepted subject to sight of positive model. Signed Date
Models _____ Die trim _____ Metal _____ Ceramic _____ Other _____ Finish & Disinfect _____
This Custom Made Device is for the exclusive use of the Patient named above and conforms to the
relevant essential requirements set out in Annex 1 of the Medical Devices Directive (93/42/EEC)
MHRA Reg no. CA003666
Any relevant essential requirements that have not been met are listed overleaf
All goods are supplied in a non-sterile condition and should not be subjected to extremes of heat or cold

Final Inspection Signed Date