NEW CLIENT INFOMATION

PLEASE FILL OUT THIS FORM AND RETURN TO US

DOCTOR: _____ EMAIL: _____ LICENSE NO.: _____

BILLING ADDRESS: _____ CITY: _____ ST, ZIP _____

PHONE NUMBER: (_____) _____ FAX NUMBER: (_____) _____

PLEASE DESIGNATE A CONTACT PERSON THAT WILL HANDLE THE ONGOING RELATIONSHIP WITH US

(NAME) _____ (TELEPHONE/MOBILE NO.) _____

BILLING CONTACT PERSON: (NAME) _____ (TELEPHONE/MOBILE NO.) _____

PLEASE INDICATE YOUR BUSINESS HOURS OPEN DURING A NORMAL WORK WEEK:

(MON) _____ (TUE) _____ (WED) _____ (THU) _____ (FRI) _____ LUNCH _____

IN CASE WE NEED TO REACH YOU ABOUT A SPECIFIC CASE, AND YOU ARE NOT IN YOUR OFFICE, PLEASE DESIGNATE TWO ALTERNATE TELEPHONE NUMBERS WHERE YOU MAY BE REACHED.

HOME (_____) _____ MOBILE/TEXT: (_____)_____

PREFERENCES

OCCLUSAL CONTACTS
☐ HEAVY CONTACT ☐ OUT OF OCCLUSAL ☐ SLIGHTLY OUT ☐ OTHER _____

OCCLUSAL ANATOMY
☐ PRIMARY ONLY ☐ PRIMARY&SECONDARY ☐ NATURAL ANATOMY ☐ OTHER _____

OCCLUSAL STAINING
☐ NONE ☐ LIGHT (ORANGE) ☐ HEAVY (BROWN) ☐ OTHER _____

OCCLUSAL ADJUSTMENT WHEN NEEDED:
☐ METAL OCCLUSAL ☐ REDUCE PREP. ☐ ADJUST OPPOSING ☐ OTHER _____

INTERPROXIMAL CONTACTS
☐ NORMAL ☐ HEAVY & BROAD ☐ NONE ☐ OTHER _____

EMBRASURE SPACING
☐ NORMAL OPENING ☐ WIDE OPENING ☐ CLOSED ☐ OTHER _____

DIE SPACER
☐ LIGHT (ONE COAT) ☐ MEDIUM (TWO COATS) ☐ HEAVY ☐ OTHER _____

PONTIC DESIGN
☐ RIDGE LAP  ☐  ☐  ☐  ☐ OVATE 

OTHERS: NOT MENTIONED ABOVE (PLEASE PRINT) _____

By signing this form, I agree that: a. All items supplied remain the property of the laboratory until payment is received. b. All restorations are constructed to the specification prescribed on the laboratory work ticket. The laboratory is not responsible for the suitability of that specification. c. All prices are subject to alteration without prior notice. The client is responsible for any additional costs or charges incurred through changing instructions or delivery dates after the work has been accepted by the laboratory. d. The laboratory holds no responsibility for any mistake due to the unclear instructions or lack of information. f. You agree to pay the full payment by the 21st of each month or there will be an added finance charge of $40 or 1.98% per month to your total balance whichever is greater. Please read INSTRUCTION section at www.theartofaesthetics.com.

SIGNATURE: _____ **DATE:** _____

TM

the art of aesthetics, inc.