NEW CLIENT INFOMATION

PLEASE FILL OUT THIS FORM AND EMAIL TO brightbitesdentallab@gmail.com

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 _____

PREFERENCES (if no preference, please write "N/A.")

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

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

PREFERRED SCREWTI BASE, IF NOT OTHERWISE SPECIFIED
DIRECT TO MUA _____ TI BASE _____

PONTIC/INTAGLIO PRESSURE:
LIGHT MEDIUM HEAVY ☐ 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 designed 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 but a good faith attempt to give notice of new fees will be provided. 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 15th 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.

SIGNATURE: _____ DATE: _____

BRIGHT BITES DENTAL LAB

Bright Bites Dental Lab, LLC