- PLUS -

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PFM: $45
EMAX: $69
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RX Date: ______________________________

Deliver by: ______________________________

Patient Name: ______________________________

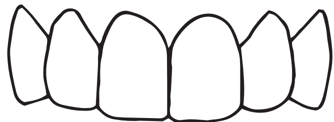
Male: Female: Approx. Age: __________

TEETH NUMBERS

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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Shade Details

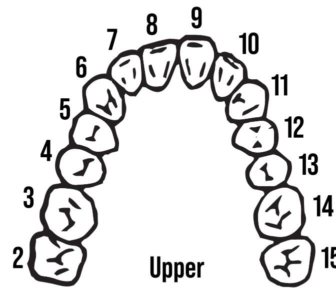
Shade: ______________ Stump Shade: ______________

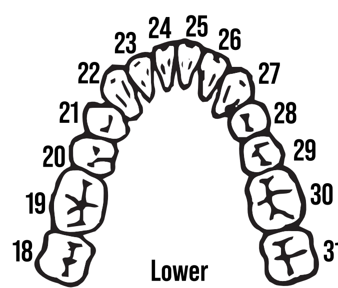


By filling out this RX,
I agree to pay NExT Plus price rates.

Account Number: ______________________________

Please write below your case instructions.
Please be as detailed as possible to avoid any delay or remake.





______________________ Gum Shade

______________________ Teeth Shade

Signature: ____________________ Dr. License Number: ____________________ Doctor's or Assistant's Cell Number: ____________________

I understand that any illegible or incomplete RX script will delay the delivery of the case.