

Dental Laboratory

---

## Schedule H Form

---

Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Patients Name \_\_\_\_\_

Case # \_\_\_\_\_ Date \_\_\_\_\_

Case Type \_\_\_\_\_ Date Required \_\_\_\_\_

**SPECIAL INSTRUCTIONS**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

