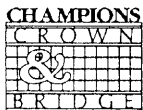


QUALITY CONTROL - DOCTOR

PATIENT _____

DATE _____

	(-) GOOD (+)
1. SEATING TIME _____	□ □ <input type="checkbox"/> □ □
2. CONTACTS _____	□ □ <input type="checkbox"/> □ □
3. MARGINS _____	□ □ <input type="checkbox"/> □ □
4. OCCLUSION _____	□ □ <input type="checkbox"/> □ □
5. SHADE _____	□ □ <input type="checkbox"/> □ □
6. PONTIC-RIDGE RELATIONSHIP _____	□ □ <input type="checkbox"/> □ □
7. CONTOUR _____	□ □ <input type="checkbox"/> □ □
8. ESTHETICS _____	□ □ <input type="checkbox"/> □ □
9. COMMENTS _____	□ □ <input type="checkbox"/> □ □



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