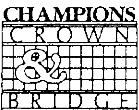
QUALITY CONTROL - LAB

DOCTOR ______________________ *DATE* __________

PATIENT ______________________________________

RESTORATION __________________ *TOOTH NO.* __________

	(-) GOOD (+)
1. RX INSTRUCTIONS	☐ ☐ ☐ ☐ ☐
2. OCCLUSAL CLEARANCE	☐ ☐ ☐ ☐ ☐
3. BITE	☐ ☐ ☐ ☐ ☐
4. CONTACTS	☐ ☐ ☐ ☐ ☐
5. OPPOSING MODEL	☐ ☐ ☐ ☐ ☐
6. PREP	☐ ☐ ☐ ☐ ☐
7. IMPRESSION	☐ ☐ ☐ ☐ ☐
8. SHADE DESCRIPTION	☐ ☐ ☐ ☐ ☐
9. COMMENTS	☐ ☐ ☐ ☐ ☐



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