Mabel DENTAL LAB MabelDental.com

YOUR OPINION MATTERS

Tell us how we're doing. Please provide us with your case feedback.

Doctor: _____ Patient: _____

Date: _____

FIXED RESTORATIONS (1 = worst; 5 = best)

Rx –preferences followed	1	2	3	4	5	n/a
Margins	1	2	3	4	5	n/a
Contacts	1	2	3	4	5	n/a
Fit	1	2	3	4	5	n/a
Shade	1	2	3	4	5	n/a
Occlusion	1	2	3	4	5	n/a
Esthetics	1	2	3	4	5	n/a
Contour	1	2	3	4	5	n/a
Overall Effect / Finish	1	2	3	4	5	n/a

REMOVABLE RESTORATIONS / ORTHO (1 = worst; 5 = best)

Rx – preferences followed	1	2	3	4	5	n/a
Borders + Flanges: Thickness / Uniform	1	2	3	4	5	n/a
Retention	1	2	3	4	5	n/a
Occlusion	1	2	3	4	5	n/a
Tooth Selection: Shade / Shape / Size	1	2	3	4	5	n/a
Anterior / Posterior Set-up	1	2	3	4	5	n/a
Finish / Polish	1	2	3	4	5	n/a
Framework: Fit / Passive	1	2	3	4	5	n/a
Clasp: Contour / Fit	1	2	3	4	5	n/a

LABORATORY EVALUATION (1 = worst; 5 = best)

Received on time?	Yes	No				
Overall Turnaround Time	1	2	3	4	5	n/a
Case Communication	1	2	3	4	5	n/a
Would You Recommend Us?	Yes	No				

PLEASE CALL ME __

Other Remarks:

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