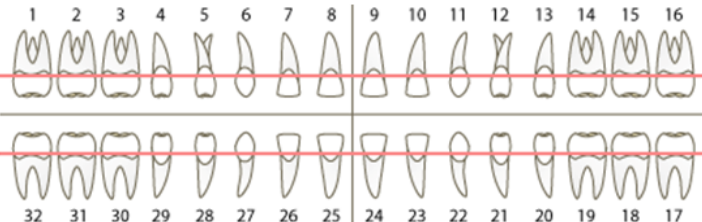





Dr. / Office: _____ Patient: _____

Address: _____ Due Date by 5PM: _____

Phone #: _____ Email: _____

<p>Porcelain Fused to:</p> <input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> White-Precious 40% <input type="checkbox"/> Yellow-Precious 87% <input type="checkbox"/> Captek <p>All Ceramic Restorations:</p> <input type="checkbox"/> IPS e.max <input type="checkbox"/> Zirconia (layered) (PFZ) <input type="checkbox"/> Bruxzir Solid Zr <input type="checkbox"/> Bruxzir Solid Anterior <p>Full Cast Restorations:</p> <input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> Y+ 2% Gold (yellow) <input type="checkbox"/> 40% Gold (white) <input type="checkbox"/> 60% Gold (yellow) <input type="checkbox"/> 75% Gold (yellow) <p>Indirect Composite:</p> <input type="checkbox"/> Gradia <p>Implants:</p> <input type="checkbox"/> Screw Retained <input type="checkbox"/> Cementable <p>Type: _____</p> <p>Diameter: _____</p> <p>Miscellaneous:</p> <input type="checkbox"/> Temp Crown <input type="checkbox"/> Metal Occlusion <input type="checkbox"/> Porcelain Butt Margin <input type="checkbox"/> Rest <input type="checkbox"/> Diagnostic Wax Up <input type="checkbox"/> Implant Bar <input type="checkbox"/> Cast Implant Abut (UCLA)	<p>Tooth Number:</p> <p>Abutment _____ Maryland Wing _____</p> <p>Crown _____ Pontic _____</p> <p>Inlay _____ Onlay _____</p> <p>Veneer _____ Post _____</p> <div style="text-align: center;">  </div> <p>Basic Shade: Custom Shade Design: Shade Guide Used _____</p> <div style="text-align: center;">  </div> <p>Margin Design:</p> <input type="checkbox"/> No Metal Collar ★ <input type="checkbox"/> 180 Metal Collar <input type="checkbox"/> 360 Metal Collar <p>Anterior Design: Posterior Design:</p> <div style="text-align: center;">  </div> <p>Pontic Design:</p> <div style="text-align: center;">  </div> <p>Occlusal Clearance: Contacts:</p> <input type="checkbox"/> Light ★ <input type="checkbox"/> Light <input type="checkbox"/> Normal ★ <input type="checkbox"/> Tight <input type="checkbox"/> Open <input type="checkbox"/> Heavy <p>Occlusal Stain:</p> <input type="checkbox"/> None ★ <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <p>Fit (Die Spacer coats): <input type="checkbox"/> x1 <input type="checkbox"/> x2 ★ <input type="checkbox"/> x3</p> <div style="background-color: #FFD700; padding: 5px; text-align: center;"> <p>If Insufficient Room: (must select)</p> <input type="checkbox"/> Reduce Opposing <input type="checkbox"/> Place metal Island/Occ <input type="checkbox"/> Reduction Coping </div>	<p>Removable Prosthetics:</p> <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <p>Tissue Shade:</p> <input type="checkbox"/> Clear <input type="checkbox"/> Light Pink <input type="checkbox"/> Regular Pink <input type="checkbox"/> Dark Pink <input type="checkbox"/> Lucitone 199 (extra charge) <input type="checkbox"/> Ethnic (Meharry) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <p>Tooth Shade:</p> <p>_____</p> <p>Partial Denture:</p> <p>Type of Material:</p> <input type="checkbox"/> Valplast <input type="checkbox"/> Cr Co <input type="checkbox"/> Vitallium <input type="checkbox"/> Framework only <input type="checkbox"/> Set Teeth Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Complete (without Try-in) <p>Type of Tooth:</p> <input type="checkbox"/> Economic (yamahachi) <input type="checkbox"/> Ivostat (extra charge) <input type="checkbox"/> Ivoclar (extra charge) <p>Full Denture:</p> <input type="checkbox"/> Wax Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Complete (Without Try-in) <input type="checkbox"/> Acrylic (Immediate) Denture <p>Removable Extras:</p> <input type="checkbox"/> Bite Rims <input type="checkbox"/> Custom Trays <input type="checkbox"/> Flipper <input type="checkbox"/> Repair <input type="checkbox"/> Reline <input type="checkbox"/> Rebase <input type="checkbox"/> Add Valplast Clasp <input type="checkbox"/> Add Clear Clasp <input type="checkbox"/> Add Cast Clasp <input type="checkbox"/> Add Ball Clasp <input type="checkbox"/> Hard Mouth Guard <input type="checkbox"/> Soft Mouth Guard <input type="checkbox"/> Hard/Soft Mouth Guard <input type="checkbox"/> Bleaching Tray <input type="checkbox"/> Surgical Stent <input type="checkbox"/> ID In Denture
--	--	---

Rx Additional Instructions