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YOUR DENTAL LABORATORY SOLUTION

|  |  |  |                         |
|--|--|--|-------------------------|
| DOCTOR   |  |  |                         |
| PATIENT  |  |  |                         |
| <input type="checkbox"/> CUSTOM SHADE<br>PATIENT PHONE #   | DOCTOR'S SHADE<br>  | LAB USE ONLY   | LAB USE ONLY            |
| WORK _____<br>HOME _____<br>CELL _____   | <input type="checkbox"/> STUMP SHADE<br><input type="checkbox"/> OPALESCENCE PORCELAIN   |  |                         |
| <b>PONTIC DESIGN</b>   | <b>METAL DESIGN</b>  | <b>FACIAL MARGIN</b>   | <b>FINISH DATE/TIME</b> |
| <input type="checkbox"/> PARTIAL<br><input type="checkbox"/> SANITARY<br><input type="checkbox"/> HIGH WATER     |   | <input type="checkbox"/> SHOW NO METAL<br><input type="checkbox"/> METAL MARGIN<br><input type="checkbox"/> PORCELAIN SHOULDER<br>____ QTY |                         |
| <b>ALL CERAMIC</b>   | <b>PORCELAIN FUSED TO METAL</b>  | <b>OCCCLUSION</b>  |                         |
| <input type="checkbox"/> e.max®<br><input type="checkbox"/> PFZ ZIRCONIA<br><input type="checkbox"/> IPS EMPRESS | <input type="checkbox"/> WHITE GOLD (NOBLE)<br><input type="checkbox"/> WHITE GOLD (HIGH NOBLE)<br><input type="checkbox"/> YELLOW GOLD (HIGH NOBLE) | <input type="checkbox"/> IN OCCCLUSION<br><input type="checkbox"/> OUT OF OCCCLUSION<br><input type="checkbox"/> FOIL RELIEF               |                         |
| <b>IMPLANT</b>   | <b>FULL GOLD</b>   | <b>ALLOY LAB USE ONLY</b>  |                         |
| <input type="checkbox"/>   | <input type="checkbox"/> AU%   |  |                         |

|   |                                      |                       |
|---|--------------------------------------|-----------------------|
| <b>INCLUDED WITH CASE</b>                                   | <b>RX INSTRUCTIONS</b>               | <b>ALL CERAMIC</b>    |
| <input type="checkbox"/> IMPRESSION                         | TOOTH # _____                        | <input type="text"/>  |
| <input type="checkbox"/> OPPOSING IMPRESSION/MODELS         |                                      | <b>STUMP/ND SHADE</b> |
| <input type="checkbox"/> BITE REGISTRATION                  |                                      |                       |
| <input type="checkbox"/> STUDY IMPRESSION/MODELS            |                                      |                       |
| <input type="checkbox"/> BITE FORK                          |                                      |                       |
| <input type="checkbox"/> IMPLANT PARTS (SPECIFY PARTS LIST) |                                      |                       |
| <input type="checkbox"/> PHOTOS/COLOR MAP                   |                                      |                       |
| <input type="checkbox"/> SURGEON'S LETTER                   |                                      |                       |
| <input type="checkbox"/> NOTE FROM DR.                      |                                      |                       |
| <input type="checkbox"/> OTHER _____                        | <input type="checkbox"/> NOTE TO DR. |                       |



TODAY'S DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
LIC. # \_\_\_\_\_ STATE: \_\_\_\_\_



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