

Dr. \_\_\_\_\_

Patient. \_\_\_\_\_  Male  Female Age \_\_\_\_\_  
First Last

Date Sent \_\_\_\_\_ Date Required \_\_\_\_\_ Time \_\_\_\_\_

**Fixed**

- RCT  Non-RCT  Wax-up  
 PFM  FGC  
 Implant  
 Layering Zirconia  Full Zirconia  
 Layering E.Max  Monolithic E.Max

**Ceramic Alloy**

- White High Noble  Yellow High Noble (88% Au)

**FGC Alloy**

- 62% Au  77% Au

**Occlusion**

- Porcelain  Metal

**Margin**

- Zero  Butt  Fine Metal

**Foil Relief**

- Foil Relief  No Relief  Extra Relief

**Contact**

- Broad  Normal  Point





Will the opposing teeth be restored?  Yes  NoOkay to relieve opposing?  Yes  NoOkay to relieve prep?  Yes  No**Removables**

- Full Denture  
 Partial Denture  
 Valplast

**Splints**

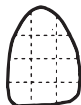
- Upper  Lower  
 Thermoflex  
 Dual flex  
 Hard Acrylic  
 Mouth Guard  
 NTI

**Pontic Design**

- Harmony   
 Hygienic   
 Ridge Lap   
 Cone 

**Rx**

Shade/Colour



**Enclosed**  Impression  Opposing  Bite  Photos Emailed  Other