For Lab Use Only

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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 ☐ No
Okay to relieve opposing? ☐ Yes ☐ No
Okay 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