

Doctor's Name: _____ Patient: _____

Address: _____ Patient Appt Date & Time: _____

Phone #: _____ Dr's Signature: _____

<p>Porcelain Fused to:</p> <p><input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> White-Precious 40% <input type="checkbox"/> White-Precious 52% <input type="checkbox"/> Yellow-Precious <input type="checkbox"/> Captek</p> <p>All Ceramic Restorations:</p> <p><input type="checkbox"/> IPS e.max <input type="checkbox"/> IPS Empress <input type="checkbox"/> Milled Zirconia <input type="checkbox"/> Full Contour Zirconia</p> <p>Full Cast Restorations:</p> <p><input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> 40% Gold (white) <input type="checkbox"/> 60% Gold (yellow) <input type="checkbox"/> 75% Gold (yellow)</p> <p>Metal-Free Composite:</p> <p><input type="checkbox"/> Adoro</p> <p>Implants:</p> <p><input type="checkbox"/> Screw Retained <input type="checkbox"/> Cementable</p> <p>Type: _____</p> <p>Diameter: _____</p> <p>Miscellaneous:</p> <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"/> Shade Blend <input type="checkbox"/> Locator <input type="checkbox"/> Attachment (ERA) <input type="checkbox"/> Key & Key way <input type="checkbox"/> Locator <input type="checkbox"/> Telescope <input type="checkbox"/> Implant Bar <input type="checkbox"/> Cast Implant Abut (UCLA)</p>	<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> <p><input type="checkbox"/> No Metal Collar <input type="checkbox"/> 180 Metal Collar <input type="checkbox"/> 360 Metal Collar</p> <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> <p><input type="checkbox"/> Light <input type="checkbox"/> Tight <input type="checkbox"/> Open <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy</p> <p>Occlusal Stain:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy</p> <p>Fit (Die Spacer coats): <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3</p> <div style="background-color: #e0ffe0; padding: 5px;"> <p>If Insufficient Room: (must select)</p> <p><input type="checkbox"/> Reduce Opposing <input type="checkbox"/> Place metal Island/Occ <input type="checkbox"/> Reduction Coping</p> </div>	<p>Removable Prosthetics:</p> <p><input type="checkbox"/> UPPER <input type="checkbox"/> LOWER</p> <p>Tissue Shade:</p> <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> <p>Tooth Shade:</p> <p>_____</p> <p>Partial Denture:</p> <p>Type of Material:</p> <p><input type="checkbox"/> Valplast <input type="checkbox"/> Cr Co <input type="checkbox"/> Vitallium</p> <p><input type="checkbox"/> Framework only <input type="checkbox"/> Set Teeth Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Complete (without Try-in)</p> <p>Type of Tooth:</p> <p><input type="checkbox"/> Economic (yamahachi) <input type="checkbox"/> Ivostat (extra charge) <input type="checkbox"/> Ivoclar (extra charge)</p> <p>Full Denture:</p> <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> <p>Removable Extras:</p> <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</p>
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