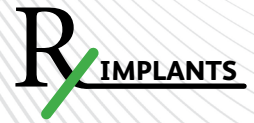
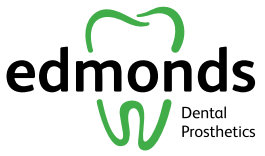


Date: \_\_\_\_\_  
 Dr. \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Patient: \_\_\_\_\_ Age: \_\_\_\_\_  
 Male Female

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**ENCLOSED WITH CASE**

Impression	Master Model	Old Crown
Study Model	Diag. Wax-up	Photos
Denture	Attachment	Bite Relation
Facebow	Opposing Model	Articulator

	Amount Included	
Copings	_____	Has this case been disinfected? Yes No
Analogs	_____	
Abutments	_____	*Please send a copy of the surgical note
Screws	_____	

**ABUTMENT SELECTION**

Pt. Specific Milled:  
 Titanium Gold Hue Zirconia  
 UCLA:  
 High Noble White High Noble Gold  
 Zimmer/Biomet Encode  
 Temporary

(Please include impression components with case)

Brand	Type	Size	Tooth#
_____	_____	_____	_____
_____	_____	_____	_____

Digital Scan:  
 Date Sent: \_\_\_\_\_ Time Sent: \_\_\_\_\_  
 System: \_\_\_\_\_

**RESTORATION SELECTION**

E-Zr Natural (Anterior)	E-Zr Total (Posterior)
Porcelain to High Noble Yellow	Full Cast
Porcelain to High Noble White	Porcelain to Base Metal
Porcelain to Noble White	

**SPECIAL INSTRUCTIONS**

Please Call \_\_\_\_\_ Please Text #: \_\_\_\_\_  
 Request Return Date: \_\_\_\_\_ Time: \_\_\_\_\_

Cementable  
 Screwmentable  
 Place screw access hole, but do not cement  
 Place screw access hole, and cement  
 (extra charge for cement)

**ABUTMENT EMERGENCE PROFILE**

Anatomical Tissue Displacement  
 Blanching Ok Moderate Tissue Displacement (default)  
 Cementable

SHADE Final Shade \_\_\_\_\_  
 Pink Porcelain at Gingiva? Yes No

**ABUTMENT MARGIN DESIGN**

Shoulder (default)  
 Chamfer  
 Feather

OCCLUSAL STAINING \*DEFAULT  
 None Light\* Medium Heavy

EMBRASURES  
 Open Closed

CONTACTS  
 Broad & Tight Pinpoint Light

SURFACE ANATOMY  
 Smooth Moderate\* Textured

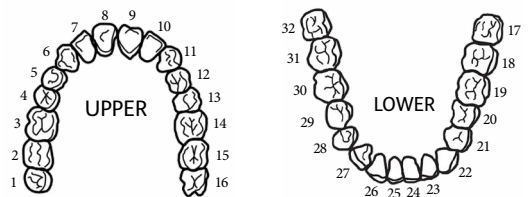
**IMPLANTS**

If no occlusal clearance:  
 Call Adjust Opposing  
 Surgical Guide

**SIGN & COMPLETE PRESCRIPTION**

Payment is due upon receipt of statement. Payment not received by the end of the following month is subject to a 1.5% per month service charge on the unpaid balance plus all collection costs if incurred. Your signature is acceptance of these terms.  
 Each prescription must be completed and signed.

X \_\_\_\_\_  
 Doctor Signature License Number



**PLEASE PRINT TWO COPIES OF COMPLETED SCRIPT. KEEP ONE FOR YOUR RECORDS AND SEND ONE WITH YOUR CASE**