Date: _____

Dr. _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Patient: _____ Age: _____

○ Male ○ Female

CASE REQUIREMENTS

○ Digital Scan (.stl Format, Both Arches)

Date Sent: _____ Time Sent: _____

System: _____

○ CBCT (DICOM, Uncompressed Multi-File Format

Date Sent: _____ Time Sent: _____

System: _____

○ Surgical Kit Used: _____

SPECIAL INSTRUCTIONS

○ Please Call ○ Please Text #: _____

Request Return Date: _____ Time: _____

edmonds Dental Prosthetics

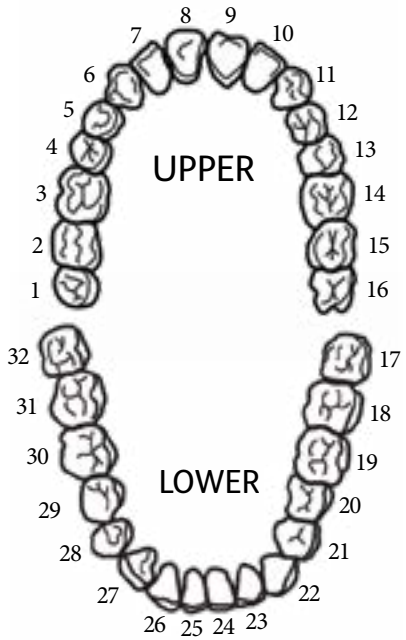
2065 W. Woodland • Springfield • MO • 65807 • 800.462.3569

MADE IN USA

Rx SURGICAL GUIDE

IMPLANT DETAILS

Please indicate desired implant site(s) as well as any teeth that will be extracted:



Surgical Guide System: _____

Please indicate desired implant brand, series, length and diameter (if known):

Tooth#	Brand	Series	Diameter	Length

Additional Information: _____

TERMS & CONDITIONS:

Edmonds Dental Prosthetics is pleased to be able to offer dental implant planning and surgical guides for your practice and patients. The information provided to you is based solely upon data furnished by you and your practice. Edmonds has no control over, or ability to verify the accuracy of the information provided to us by you and your practice, nor do we have the ability to monitor any changed conditions that have occurred with the patient since the data was provided to Edmonds.

Under these circumstances, you (the doctor) and / or the practice, have the full and final responsibility to exercise independent professional judgment concerning all risk assessment factors related to the case and verify the suitability of any dental implant placement and location for the patient. Prior to using the products and services provided to you by Edmonds, you assume the responsibility to review and verify the accuracy of the scan provided to Edmonds, which we used to develop the specifications for fabrication of the surgical guide for your patient.
Edmonds disclaims any and all expressed and implied warranties, including warranties or merchantability and fitness for purpose concerning the location of any dental implants.

If you agree to the above terms and conditions, please indicate so by signing your name below, which shall constitute your legal signature for purposes of this Treatment Planning / Surgical Guide Agreement & Disclaimer.

CONSENT:

I CERTIFY I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THIS DOCUMENT AND THE EXPLANATIONS REFERRED TO OR IMPLIED, AND THAT AFTER THOROUGH DELIBERATION, I GIVE MY CONSENT FOR THE PRODUCTION OF THE SURGICAL GUIDE RELATED TO THE PLACEMENT OF DENTAL IMPLANT(S) AS PRESENTED TO ME DURING THE CONSULTATION AND TREATMENT PLAN PRESENTATION BY EDMONDS DENTAL PROSTHETICS AND THEIR STAFF OR AS DESCRIBED IN THIS DOCUMENT.

X _____

Name (PRINT) Doctor Signature License Number

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