



www.edmondsdentalprosthetics.com

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Springfield, MO 65807 | FAX: 417.881.0484

SPECIAL INSTRUCTIONS

Please Call Please Text Phone: _____

Request Return Date: _____ Time: _____

DOCTOR INFORMATION

Date: _____

Dr. _____

Address: _____

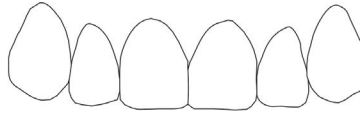
City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Patient: _____ Age: _____

Male Female

CERAMIC SHADE INSTRUCTIONS



SHADE GUIDE USED

Vita Classic Chromoscope
Vita 3-D Other: _____

Final Shade: _____ Stump Shade: _____

Non Vital Shade: _____

Photos sent to photos@edplabs.com? Yes No

Date sent: _____

SURFACE TEXTURE -STANDARD UNLESS OTHERWISE SPECIFIED

Smooth Moderate* Heavy

OCCUSAL STAINING -STANDARD UNLESS OTHERWISE SPECIFIED

None Light* Medium Heavy

PONTIC DESIGN -STANDARD UNLESS OTHERWISE SPECIFIED

High Water Hygenic Modified Ridge Lap*
Full Ridge Lap Ovate

RIDGE RELIEF -STANDARD UNLESS OTHERWISE SPECIFIED

None Slight* Medium Heavy

FACIAL MARGIN DESIGN -STANDARD UNLESS OTHERWISE SPECIFIED

Metal-porcelain junction margin*
Metal hairline or _____ mm on buccal
Porcelain butt margin (90° shoulder required)

METAL DESIGN -STANDARD UNLESS OTHERWISE SPECIFIED

- Coping with full porcelain coverage*
- Metal lingual collar with porcelain coverage
- Metal occlusal excluding buccal cusp
- Metal occlusal including buccal cusp

ENCLOSED WITH CASE

Impression	Master Model	Bite Relation
Study Model	Diag. Wax-up	Photos
Denture	Attachment	Articulator
Facebow	Opposing Model	Old Crown
Partial	Shade Tab	Implant Components

Has this case been disinfected? Yes No
Digital Scan: _____

Date Sent: _____ Time Sent: _____

System: _____

CROWN & BRIDGE / CERAMICS

PORCELAIN TO METAL

ALLOY

High Noble Yellow
High Noble White
Noble White
Base Metal

ALL CERAMIC

CerEnamel Veneer
IPS e.max

ZIRCONIA

E-Zr™ Total (Posterior)
E-Zr™ Natural (Anterior)

FULL CAST

High Noble Gold
Noble Gold
Base Metal
Post & Core

CUSTOM TEMPORARY

Temporary Crown

Tooth #: _____

Shade: _____

Temporary Bridge

Tooth #: _____

Shade: _____

GOAL OF FINAL CASE

Close Diastemas	Restore Worn Teeth
Change Shape	Normal Guidance
Move Midline	Widen Smile
Restore to CR	Feminize Smile
Straighten Teeth	Rejuvenate Smile

Lengthen Teeth	Restore Morphology
Level Occlusal Plane	Replace Missing Teeth

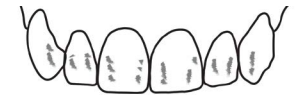
Other: _____

Teeth to be restored: _____

Teeth to be replaced: _____

TOOTH SHAPE

Maintain Existing
Match Photos



#6 ___ #7 ___ #8 ___ #9 ___ #10 ___ #11 ___

Overjet: _____ mm Overbite: _____ mm

IF NOT ENOUGH OCCUSAL CLEARANCE

Metal Occlusion	Metal Island
Reduce Opposing	Reduce Prep
Reduction Coping	

ADD THIS TO YOUR DR. PREFERENCES?

Yes No

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

