



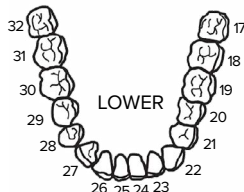
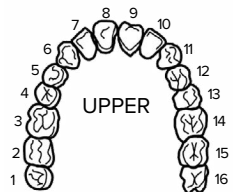
www.edmondsdentalprosthetics.com

2065 W. Woodland | 1.800.462.3569
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

ABUTMENT SELECTION

PATIENT SPECIFIC MILLED

Titanium Gold Hue Zirconia

UCLA

High Noble White High Noble Gold

ZIMMER BIOMET ENCODE

TEMPORARY

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)

NO BLANCHING

ABUTMENT MARGIN DESIGN

SHOULDER (Default)

CHAMFER

FEATHER

IMPLANTS

If no occlusal clearance:

Call Adjust Opposing

SURGICAL GUIDE

Pilot Hole
Fully Guided

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 <i>*Please send a copy of the surgical note.</i>
Analogs	_____	
Abutments	_____	
Screws	_____	

Digital Scan:

Date Sent: _____ Time Sent: _____
System: _____

(Please include impression components with case)

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

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

SHADE Final Shade
Pink Porcelain at Gingiva? Yes No

OCCUSAL STAINING *DEFAULT
None Light* Medium Heavy

EMBRASURES
Open Closed

CONTACTS
Broad & Tight Pinpoint Light

SURFACE ANATOMY *DEFAULT
Smooth Moderate* Textured

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