



DOCTOR INFORMATION

Date: _____
 Dr. Name: _____ Patient Name: _____
 Address: _____ City: _____ State: _____
 Zip: _____ Phone: _____ Email: _____
 Patient Name: _____ Age: _____ Male Female

SPECIAL INSTRUCTIONS

Request Return Date: _____ Time: _____ Please Call Please Text _____

CROWN & BRIDGE / CERAMICS

ALL CERAMIC

eMax

TOOTH SHAPE

Maintain Existing

Match Photos

Follow IO Mockup

Make Ideal



#6 ___ #7 ___ #8 ___ #9 ___ #10 ___ #11 ___
 Overjet: _____mm Overbite: _____mm

ZIRCONIA

Monolithic

Multi-Layered

IF NOT ENOUGH OCCUSAL CLEARANCE

Reduce Opposing

Reduce Prep

ADD THIS TO YOUR DOCTOR PREFERENCES?

Yes No

CERAMIC SHADE INSTRUCTIONS

*STANDARD UNLESS OTHERWISE SPECIFIED

SHADE GUIDE USED

Vita Classic

Chromoscope

Final Shade: _____ Stump Shade: _____

Vita 3-D

Other: _____ Non Vital Shade: _____

Photos sent to prostheticsource@edplabs.com Yes No Date sent: _____

SURFACE TEXTURE

Smooth Moderate* Heavy

OCCUSAL STAINING

None Light* Medium Heavy

PONTIC DESIGN

High Water

Hygienic

Full Ridge Lap

Ovate

Modified Ridge Lap*

RIDGE RELIEF

None Slight* Medium Heavy

SIGN & COMPLETE

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 AND SEND ONE WITH YOUR CASE

NOTES / INSTRUCTIONS: