

Y / N

Rx DATE	DATE DUE IN OFFICE	CONFIRMED WITH LAB
DOCTOR'S NAME (PLEASE PRINT)		
DOCTOR'S ADDRESS	PHONE	
PATIENT'S NAME		SEX M / F

PLEASE CIRCLE TEETH INVOLVED

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

METAL FREE

- AUTHENTIC™ e.MAX® FELDSPATHIC
 ZIRCONIA EMPRESS®

FABRICATION PURPOSE:	<input type="checkbox"/> Correct Malalignment	<input type="checkbox"/> Close Spaces	
	<input type="checkbox"/> Increase Length	<input type="checkbox"/> Color Change	
SURFACE TEXTURE:	<input type="checkbox"/> Smooth	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
	<input type="checkbox"/> High Glaze	<input type="checkbox"/> Polished Glaze	<input type="checkbox"/> Low Glaze

DIAGNOSTIC WAXUP

PLEASE CIRCLE TEETH INVOLVED

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

CASE GOAL

SIGNATURE OF DENTIST

LICENSE #

ITEMS SENT WITH CASE

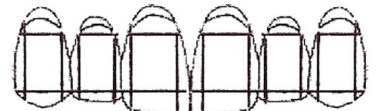
- | | | |
|--|--|---|
| MODELS | BITE REG | PHOTOS |
| <input type="checkbox"/> Pre-op <input type="checkbox"/> Master | <input type="checkbox"/> Bite Reg. w/ stick | <input type="checkbox"/> CD |
| <input type="checkbox"/> Facebow <input type="checkbox"/> Opposing | <input type="checkbox"/> Bite Reg. w/o stick | <input type="checkbox"/> Thumb Drive |
| <input type="checkbox"/> Diag Wax <input type="checkbox"/> Temp | | <input type="checkbox"/> Printed Pictures |

SHADE CHART

STUMP SHADE	SHADE	INGOT BLOCK
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VALUE:

- High (Bright)
 Medium
 Low



OCCLUSAL STAIN:

- None Light Medium Heavy
 Hypo-Calcification Post. Occ Character



IMPLANT

TEETH INVOLVED: _____
 BRAND: _____
 TYPE: Zirconia Custom Titanium

CONSULTATION

TEETH INVOLVED: _____
 Request: Phone Consult
 Date: _____
 Time: _____