Dental Tech Team

Diagnostic Rx

Patient's NAME: _____

☐ MALE ☐ FEMALE AGE: _____ Order Date: _____

Doctor Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

DELIVER BY 5:00 PM ON: _____

Hand-Waxed _____

Digital _____

Additive only _____

Diagnostic Wax Up Prep Kit: Y or N

Length of Centrals desired ____mm

Restore in CR or MIP

Change VDO____mm CEJ to CEJ ____ mm

Number of units ____

Crowns or veneers

Adjust gingiva, crown lengthening ____ mm

Expand buccal corridor: Y or N

Close diastema: Y or N

Photos sent Y or N

Change midline cant: Y or N

Change incisal cant: Y or N

Lengthen or shorten teeth ____ mm

Move midline (left – right ____ mm

Change over bite ____ mm and over jet ____ mm

Surface texture; Light __ Medium __ Heavy __

Change shape Y or N If yes shape _____

Facebow sent: Y or N

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