

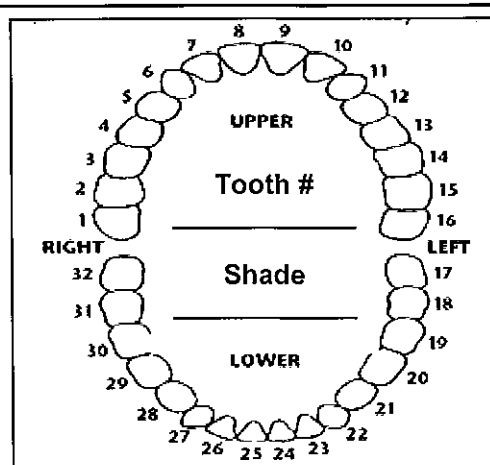
AST DENTAL LAB
841 Boardman Canfield RD
STE 310
Boardman, OH 44512

Your Reference # _____

Patient Name _____

Doctor Name _____

Date Sent _____ Due Date _____

PFM <input type="checkbox"/> Non Precious Nickel-free <input type="checkbox"/> Noble No Gold (60.5% Pd) Noble NF <input type="checkbox"/> High Noble 40% Gold (White) 75% Gold (Yellow) Captek	FULL CAST <input type="checkbox"/> Non-Precious Nickel-free <input type="checkbox"/> Noble 40% Gold (Yellow) 2% (Y+) Yellow 2% (W+) White <input type="checkbox"/> High Noble (Yellow) 58% 74.5%	ALL CERAMIC <input type="checkbox"/> eMAX <input type="checkbox"/> Procera <input type="checkbox"/> Layered Zirconia <input type="checkbox"/> Full Contour Zirconia (Bruxer) <input type="checkbox"/> Multi-Layered Aidite	COMPOSITE RESTORATION <input type="checkbox"/> Composite to Metal Crown <input type="checkbox"/> Full Composite Crown <input type="checkbox"/> Composite Inlay <input type="checkbox"/> Composite Onlay <input type="checkbox"/> Composite Veneer	Items Sent: (Circle all that apply) Single Tray _____ Triple Tray _____ Study Model _____ Opposing Model _____ Bite _____ Implant Parts _____ Other _____				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Single Unit Crown <input type="checkbox"/> Splinted Crowns <input type="checkbox"/> Bridge <input type="checkbox"/> Maryland Bridge <input type="checkbox"/> Implant </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Veneer <input type="checkbox"/> Inlay <input type="checkbox"/> Onlay <input type="checkbox"/> Post (Separated) <input type="checkbox"/> Post (Integrated) <input type="checkbox"/> Extra Metal Rest </td> <td style="width:25%; vertical-align: top;"> <input type="checkbox"/> Wax-up (Diagnostic) <input type="checkbox"/> Metal Try-in <input type="checkbox"/> Metal Coping Only <input type="checkbox"/> Zirconia Coping Only <input type="checkbox"/> Apply Porcelain Only <input type="checkbox"/> Temp Crown </td> <td style="width:25%; vertical-align: top;"> Porcelain Butt Margin <input type="checkbox"/> 360 Degree <input type="checkbox"/> 180 Degree <input type="checkbox"/> Buccal Only </td> </tr> </table>				<input type="checkbox"/> Single Unit Crown <input type="checkbox"/> Splinted Crowns <input type="checkbox"/> Bridge <input type="checkbox"/> Maryland Bridge <input type="checkbox"/> Implant	<input type="checkbox"/> Veneer <input type="checkbox"/> Inlay <input type="checkbox"/> Onlay <input type="checkbox"/> Post (Separated) <input type="checkbox"/> Post (Integrated) <input type="checkbox"/> Extra Metal Rest	<input type="checkbox"/> Wax-up (Diagnostic) <input type="checkbox"/> Metal Try-in <input type="checkbox"/> Metal Coping Only <input type="checkbox"/> Zirconia Coping Only <input type="checkbox"/> Apply Porcelain Only <input type="checkbox"/> Temp Crown	Porcelain Butt Margin <input type="checkbox"/> 360 Degree <input type="checkbox"/> 180 Degree <input type="checkbox"/> Buccal Only	TOOTH NUMBER, SHADE & STAINING (Please circle abutments & cross out pontics.) 
<input type="checkbox"/> Single Unit Crown <input type="checkbox"/> Splinted Crowns <input type="checkbox"/> Bridge <input type="checkbox"/> Maryland Bridge <input type="checkbox"/> Implant	<input type="checkbox"/> Veneer <input type="checkbox"/> Inlay <input type="checkbox"/> Onlay <input type="checkbox"/> Post (Separated) <input type="checkbox"/> Post (Integrated) <input type="checkbox"/> Extra Metal Rest	<input type="checkbox"/> Wax-up (Diagnostic) <input type="checkbox"/> Metal Try-in <input type="checkbox"/> Metal Coping Only <input type="checkbox"/> Zirconia Coping Only <input type="checkbox"/> Apply Porcelain Only <input type="checkbox"/> Temp Crown	Porcelain Butt Margin <input type="checkbox"/> 360 Degree <input type="checkbox"/> 180 Degree <input type="checkbox"/> Buccal Only					
METAL DESIGN <input type="checkbox"/> No Metal to Show <input type="checkbox"/> Buccal Collar _____ mm <input type="checkbox"/> Lingual Collar _____ mm <input type="checkbox"/> Mesial Collar _____ mm <input type="checkbox"/> Distal Collar _____ mm <input type="checkbox"/> 360 Degree Collar _____ mm <input type="checkbox"/> Metal Occlusal Full Excluding Buccal Cusps <input type="checkbox"/> Metal Lingual Full 2/3 1/2 <input type="checkbox"/> Removable Button <input type="checkbox"/> Keep metal lingual collar thickness less than 0.5mm		PONTIC DESIGN <input type="checkbox"/> Full Ridge <input type="checkbox"/> Modify Ridge Lap <input type="checkbox"/> No Contact <input type="checkbox"/> Point Contact <input type="checkbox"/> Pontic in Socket <input type="checkbox"/> Show Metal on Lingual <input type="checkbox"/> Reduce pontic area to make snug on ridge GINGIVAL EMBRASURE <input type="checkbox"/> Close <input type="checkbox"/> Natural		OCCLUSAL CONTACT <input type="checkbox"/> 0.5mm Clearance <input type="checkbox"/> No Contact <input type="checkbox"/> Light Contact <input type="checkbox"/> Full Contact INTERPROXIMAL CONTACT <input type="checkbox"/> Light Contact <input type="checkbox"/> Medium Contact <input type="checkbox"/> Heavy Contact <input type="checkbox"/> Broad Contact				
REMAKE INFORMATION (Please complete this section if returning this case for a remake) Customer Original Pan # _____ PLS Original RX # _____ Reason for Remake _____ Items being Returned <input type="checkbox"/> Original Prosthesis (Crown, Partial, Bite, Etc.) <input type="checkbox"/> Original Model Original Die Original PLS RX <input type="checkbox"/> Old Impression New Impression Study Model (Failure to provide original RX, reason, or items may result in a delay in processing this case and a charge for this remake)						IF OCCLUSAL SPACE IS NEEDED <input type="checkbox"/> Adjust opposing tooth <input type="checkbox"/> Make metal Island/Occlusal <input type="checkbox"/> Adjust Prep and Mark <input type="checkbox"/> Adjust Prep and Make reduction coping <input type="checkbox"/> Contact for discussion PREPARATION TOO BULKY OR BRIDGE NOT PARALLEL ISSUE <input type="checkbox"/> Adjust and mark in red on die <input type="checkbox"/> Adjust and make reduction coping <input type="checkbox"/> Do not adjust make as is IF BAD IMPRESSION SENT <input type="checkbox"/> Do best you can to process <input type="checkbox"/> Contact for discussion		
OTHER SPECIAL INSTRUCTIONS <div style="height: 100px; border: 1px solid black;"></div>								