S2517411 ABC

Exquisite New Beginnings
DENTAL STUDIO
New Beginnings for Your Smile

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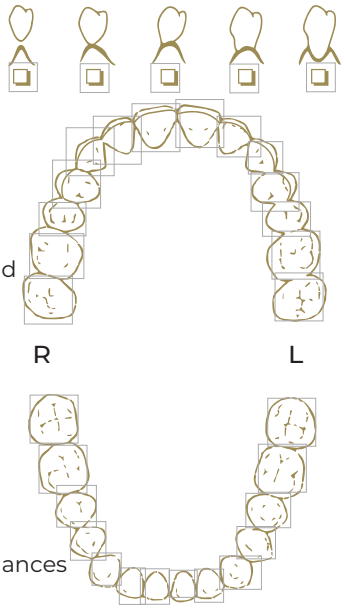
Doctor: _____ Date sent: _____
Address: _____ Date Required: _____
Patient: _____ Patient Appt: _____
Last Name First Name

Doctor Tel#: _____



To be delivered as:
- ❑ Metal Frame Try in
- ❑ Bisque Bake
- ❑ Completed

Type of margin:
- ❑ Porcelain to metal
- ❑ Butt Joint
- ❑ Metal Band

Type of Restoration:
- ❑ Zirconia
- ❑ Emax ❑ Implant
- ❑ PFM ❑ PFZ
- ❑ Full Metal Crown
- ❑ Other

Alloy:
- ❑ Non Precious
- ❑ Semi Precious
- ❑ White Gold ❑ Yellow Gold

Centric Contact:
- ❑ Foil Relief
- ❑ Positive
- ❑ Cusp to Fossa

Contacts
- ❑ Broad
- ❑ Normal
- ❑ Point

If insufficient Room?
- ❑ Please Call
- ❑ Reduction Coping
- ❑ Metal Occlusal/Lingual
- ❑ Reduce/mark on opposing

Orthodontics:
❑ Splints ❑ Mouthguard ❑ Nightguard ❑ Ortho Apliances

Denture Removables:
❑ Acrylic Partial ❑ Cast Partial ❑ Full Denture

Details:

Shade: _____ Stump Shade: _____

Implant System: _____

Parts Sent by Doctor: ❑ Yes ❑ No

Letter from Surgeon ❑ Yes ❑ No

Doctor's Signature: _____