UNICE
Dental Art Ltd.

Digital Surgical Guide Rx Form

Doctor's Name: _____ Office Name: _____

Patient Name: _____ Return Date/Time: _____

Dr's Preferred Contact: ☐ Secure E-Mail: _____ ☐ Phone: _____

Guide Type: ☐ Implant Placement ☐ Bone Reduction ☐ Fully Guided ☐ Pilot Guided

CBCT Sent by: ☐ CD/USB ☐ Secure E-Mail ☐ DDX ☐ Other: _____

CBCT Sent Date: _____

Models: ☐ Impression/Model ☐ I/O Scan ☐ Dual Scan ☐ Diagnostic Model/Wax-up/Digital

Model Sent Date: _____

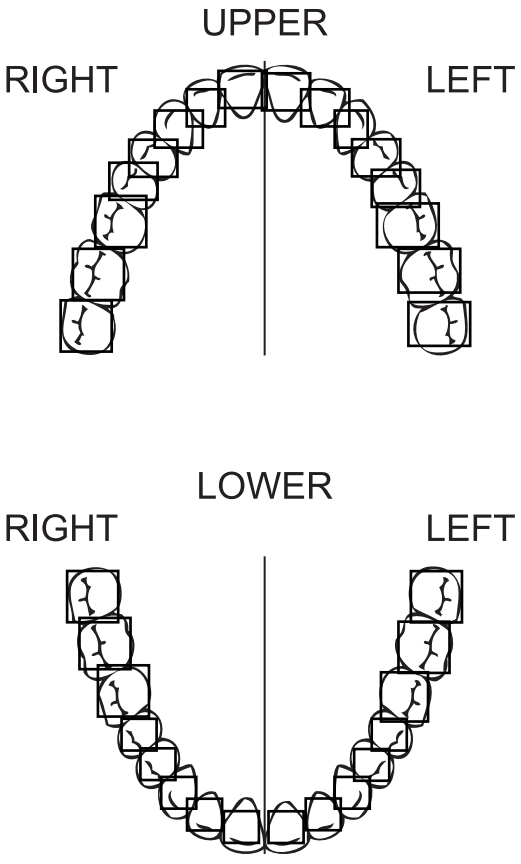
Preferred Implant System: _____

Rx_

☐ Grafting/Sinus Lift Planned

☐ Immediate Temp. Restoration

Implant Sites: (Please list tooth numbers here, or select teeth on diagram below)



233 Mayland Pl NE Calgary AB T2E 7Z8
Toll Free: 1.866.939.2515 Fax: 403.277.2518

Doctor's Signature _____