

Rx _____
Date _____

Doctor _____

Address _____

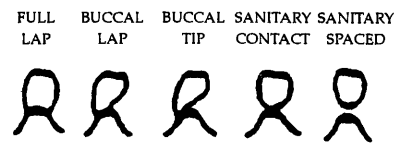
City _____ State _____ Zip _____

Patient _____

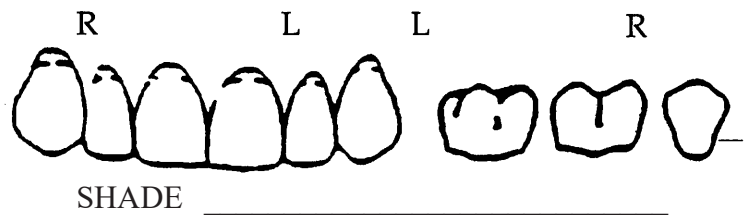
Sex _____ Age _____ Due Date _____

- Will opposing teeth be restored?
- OK to relieve opposing?
- OK to relieve die?
- Return for margin identification
- Pour solid model
- Porcelain margin _____
- Porcelain finished to margin (no metal on buccal) _____
- Small metal color _____

- Occlusal Staining
- Cervical Staining
- Patient will call for custom staining



- Doctor to trim die
- Metal try in instructions



Dentist's Signature _____

License # _____

Phone Consultation necessary with doctor: Yes No

Metal: Semi-Precious Non-Precious Gold