

**Rx Date :** \_\_\_\_\_

**Date Due in Office :** \_\_\_\_\_

(Deliver By 5PM)

Doctor's Name \_\_\_\_\_ (Please Print)

Doctor's Address \_\_\_\_\_

Patient's Name \_\_\_\_\_

Sex  M  F

Age \_\_\_\_\_

## FIXED RESTORATIONS (Please )

| PFM                                    | Full Cast Metal                                  | All Ceramic <input checked="" type="checkbox"/> |
|--|--|---|
| <input type="checkbox"/> Non-Precious  | <input type="checkbox"/> Full Cast Yellow Gold   | <input type="checkbox"/> E.max Pressed          |
| <input type="checkbox"/> Semi-Precious | <input type="checkbox"/> Full Cast White Gold    | <input type="checkbox"/> Layered Zirconia       |
| <input type="checkbox"/> High Noble    | <input type="checkbox"/> Full Cast Non-Precious  | <input type="checkbox"/> Full Contour Zirconia  |
|  | <input type="checkbox"/> Full Cast Semi-Precious | <input type="checkbox"/> Veneer                 |

### Anteriors

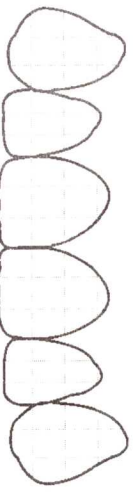
- Metal Coping
- Metal Lingual
- 3/4 Metal lingual

### Posteriors

- Metal Coping
- All porcelain coverage
- Metal Occlusal
- Excluding buccal cusp
- Metal Occlusal Including buccal cusp

### Lingual / Buccal Margin (Circle One)

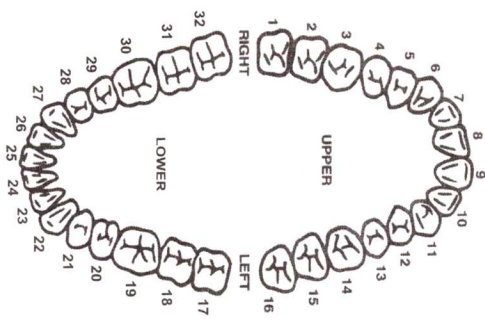
- Metal Margin
- Hairline or \_\_\_\_\_ mm
- Porcelain Butt Margin
- No Metal Showing



Shade \_\_\_\_\_

### If Insufficient Room:

- Reduce & Mark Prep
- Reduce & Mark Opposing
- Reduction Coping
- Call Me



Dr. Signature \_\_\_\_\_

License # \_\_\_\_\_

## REMOVABLE RESTORATIONS (Please )

|   |  |   |
|---|--|---|
| <b>Dentures</b><br><input type="checkbox"/> Custom Tray<br><input type="checkbox"/> Base Plate/Wax Rim<br><input type="checkbox"/> Combo Tray w/ Wax Rim<br><input type="checkbox"/> Economy Denture<br><input type="checkbox"/> Premium Denture<br><input type="checkbox"/> Transitional Denture<br><input type="checkbox"/> Immediate Denture<br><input type="checkbox"/> Denture Set-Up<br><input type="checkbox"/> Denture Finish | <b>Metal Partials</b><br><input type="checkbox"/> Standard Partial<br><input type="checkbox"/> Deluxe Partial (Vitallium 2000)<br><input type="checkbox"/> Frame with Valplast Clasps<br><input type="checkbox"/> Frame Try-In<br><input type="checkbox"/> Wax Try-In with Teeth<br><input type="checkbox"/> Bite Block<br><input type="checkbox"/> Finish | <b>Acrylic Partials</b><br><input type="checkbox"/> Acrylic Partial Flipper<br><input type="checkbox"/> Acrylic Partial w/ Clasp<br><input type="checkbox"/> Unilateral (NESBIT)<br><input type="checkbox"/> Metal / Acrylic  |
| <b>Repairs / Relines</b><br><b>Relines</b><br><input type="checkbox"/> Hard <input type="checkbox"/> Soft<br><b>Repairs</b><br><input type="checkbox"/> Tooth <input type="checkbox"/> Fractures<br><input type="checkbox"/> Clasp  | <b>Flexible Partials</b><br><input type="checkbox"/> Valplast™<br><input type="checkbox"/> Unilateral Valplast™<br><input type="checkbox"/> Clear Frame<br><input type="checkbox"/> Set-Up<br><input type="checkbox"/> Finish  | <b>Shade</b><br><b>Acrylic</b> <input type="checkbox"/> Standard <input type="checkbox"/> Pink<br><input type="checkbox"/> Light Pink <input type="checkbox"/> Menarry<br><input type="checkbox"/> Menarry<br>Tooth Shade _____<br>Tooth Mold _____<br>Tooth Make _____ |
| <b>Specialty Products</b><br><input type="checkbox"/> Hard Clear Nightguard<br><input type="checkbox"/> Hard / Soft Nightguard<br><input type="checkbox"/> Bleaching Tray<br><input type="checkbox"/> Vacuum Nightguard   |  |   |

### Rx SPECIFIC INSTRUCTIONS: