

DATE SENT

APPT. DATE

CASE #

DOCTOR

Phone No.

address

PATIENT

Age _____ Sex M F

address

CROWN AND BRIDGE

	NO. UNITS	ALLOY
Pfm <input type="checkbox"/>	_____	High Noble <input type="checkbox"/>
All cast <input type="checkbox"/>	_____	Noble <input type="checkbox"/>
All ceramic <input type="checkbox"/>	_____	Base <input type="checkbox"/>
Composite <input type="checkbox"/>	_____	

	YES	NO
Porc. shoulder <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buccal metal color <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metal Occ. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foil Occ. Relief <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PONTIC DESIGN (Circle)



CHARACTERIZATION - MOLD



Shade _____ Mold _____
Stump Shade _____

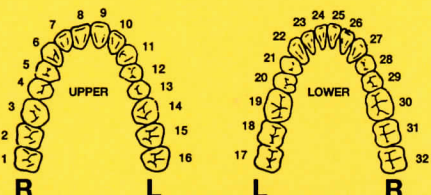
PROSTHETICS

Tryin
Finish
Rugae
Post Dam
Palatal Relief
Name Tag

Shade _____ Mold _____

Anteriors Acrylic Porc.
Posteriors Acrylic Porc.

Square Tapering Ovoid
Vigorous Delicate Soft



Rx

Additional Instructions ►

Drs. Signature

License No.