



CASE NO. _____

RUSH *See rush schedule fees
1 day minimum prior to patient appointment date

Rx DATE / / **DUE DATE** / /

Dr.Name _____ Patient _____

Account# _____ Dr.Phone _____

Address _____ City, State _____

IMPLANT PLATFORM

- ASTRA
- NOBEL
- STRAUMANN
- OTHER _____

OCCLUSION

- IN-OCCCLUSION
- OUT OF OCCCLUSION

EMBRASURES

- CLOSED
- OPEN

PROXIMAL CONTACTS

LIGHT _____ HEAVY _____ POINTY _____ BROAD _____

ABUTMENT TYPE

- CUSTOM ABUTMENT
- SCREW RETAINED
- STOCK

DESIRED SHADE _____



CERVICAL _____ BODY _____ INCISAL _____

MATERIAL TYPE

- TITANIUM
- GOLD HUE TITANIUM
- ZIRCONIA
- PRECIOUS
- SEMI-PRECIOUS
- NON-PRECIOUS

INCISAL TRANSLUCENCY

CERVICAL _____ BODY _____ INCISAL _____

INDICATE TOOTH NUMBERS AND CIRCLE NUMBER FOR BRIDGE

UPPER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

LOWER 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

IMPLANT _____ PLATFORM TYPE _____

RESTORATION TYPE

- LAYERED ZIRCONIA CROWN
- FULL CONTOUR ZIRCONIA CROWN
- LAYERED LITHIUM DISILICATE CROWN
- MONOLITHIC LITHIUM DISILICATE CROWN
- PFM

EMERGENCE PROFILE FOR ABUTMENT



MINIMAL TISSUE DISPLACEMENT

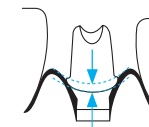


TISSUE DISPLACEMENT



ANATOMICAL TISSUE DISPLACEMENT

ABUTMENT MARGIN DEPTH



FACIAL _____ MESIAL _____
LINGUAL _____ DISTAL _____

*if left blank default values will be used

DR. SIGNATURE _____ D.D.D. LICENSE# _____