

FIXED RESTORATIONS RX

Lab Name: _____



Your Reference # _____

Patient Name _____

Doctor Name _____

Date Sent _____ Due Date _____

1805 LOUCKS RD SUITE 300 YORK, PA 17408

Phone: 888-776-5229 Fax: 717-356-2525

**Promo Code: FREECROWN
First Zirconia Crown Free**

<p>PFM</p> <input type="checkbox"/> Non-Precious Nickel-free <input type="checkbox"/> Noble No Gold (60.5% Pd) Noble NF <input type="checkbox"/> High Noble 40% Gold (White) 75% Gold (Yellow)	<p>FULL CAST</p> <input type="checkbox"/> Non-Precious Nickel-free <input type="checkbox"/> Noble 40% Gold (Yellow) 2% (Y+) Yellow 2% (W+) White <input type="checkbox"/> High Noble (Yellow) 58% 74.5%	<p>ALL CERAMIC</p> <input type="checkbox"/> eMAX <input type="checkbox"/> Procera <input type="checkbox"/> Layered Zirconia <input type="checkbox"/> Full Contour Zirconia (Bruxer) <input type="checkbox"/> Multi-Layered Aidite	<p>COMPOSITE RESTORATION</p> <input type="checkbox"/> Composite to Metal Crown <input type="checkbox"/> Full Composite Crown <input type="checkbox"/> Composite Inlay <input type="checkbox"/> Composite Onlay <input type="checkbox"/> Composite Veneer	<p>Items Sent: (Circle all that apply)</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Single Tray</td> <td><input type="checkbox"/> Triple Tray</td> </tr> <tr> <td><input type="checkbox"/> Study Model</td> <td><input type="checkbox"/> Opposing Model</td> </tr> <tr> <td><input type="checkbox"/> Bite</td> <td><input type="checkbox"/> Implant Parts</td> </tr> </table> <p>Other _____</p>	<input type="checkbox"/> Single Tray	<input type="checkbox"/> Triple Tray	<input type="checkbox"/> Study Model	<input type="checkbox"/> Opposing Model	<input type="checkbox"/> Bite	<input type="checkbox"/> Implant Parts
<input type="checkbox"/> Single Tray	<input type="checkbox"/> Triple Tray									
<input type="checkbox"/> Study Model	<input type="checkbox"/> Opposing Model									
<input type="checkbox"/> Bite	<input type="checkbox"/> Implant Parts									

<input type="checkbox"/> Single Unit Crown <input type="checkbox"/> Splinted Crowns <input type="checkbox"/> Bridge <input type="checkbox"/> Maryland Bridge <input type="checkbox"/> Implant	<input type="checkbox"/> Veneer <input type="checkbox"/> Inlay <input type="checkbox"/> Onlay <input type="checkbox"/> Post (Separated) <input type="checkbox"/> Post (Integrated) <input type="checkbox"/> Extra Metal Rest	<input type="checkbox"/> Wax-up (Diagnostic) <input type="checkbox"/> Metal Try-in <input type="checkbox"/> Metal Coping Only <input type="checkbox"/> Zirconia Coping Only <input type="checkbox"/> Apply Porcelain Only <input type="checkbox"/> Temp Crown	<p>Porcelain Butt Margin</p> <input type="checkbox"/> 360 Degree <input type="checkbox"/> 180 Degree <input type="checkbox"/> Buccal Only
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TOOTH NUMBER, SHADE & STAINING
(Please circle abutments & cross out pontics.)

UPPER
 Tooth # _____
 Shade _____
LOWER

<p>METAL DESIGN</p> <input type="checkbox"/> No Metal to Show <input type="checkbox"/> Buccal Collar _____mm <input type="checkbox"/> Lingual Collar _____mm <input type="checkbox"/> Mesial Collar _____mm <input type="checkbox"/> Distal Collar _____mm <input type="checkbox"/> 360 Degree Collar _____mm <input type="checkbox"/> Metal Occlusal Full Excluding Buccal Cusps <input type="checkbox"/> Metal Lingual Full 2/3 1/2 <input type="checkbox"/> Removable Button <input type="checkbox"/> Keep metal lingual collar thickness less than 0.5mm	<p>PONTIC DESIGN</p> <input type="checkbox"/> Full Ridge <input type="checkbox"/> Modify Ridge Lap <input type="checkbox"/> No Contact <input type="checkbox"/> Point Contact <input type="checkbox"/> Pontic in Socket <input type="checkbox"/> Show Metal on Lingual <input type="checkbox"/> Reduce pontic area to make snug on ridge	<p>OCCLUSAL CONTACT</p> <input type="checkbox"/> 0.5mm Clearance <input type="checkbox"/> No Contact <input type="checkbox"/> Light Contact <input type="checkbox"/> Full Contact	<p>INTERPROXIMAL CONTACT</p> <input type="checkbox"/> Light Contact <input type="checkbox"/> Medium Contact <input type="checkbox"/> Heavy Contact <input type="checkbox"/> Broad Contact
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IF OCCLUSAL SPACE IS NEEDED

 Adjust opposing tooth
 Make metal Island/Occlusal
 Adjust Prep and Mark
 Adjust Prep and Make reduction coping
 Contact for discussion

PREPARATION TOO BULKY OR BRIDGE NOT PARALLEL ISSUE

 Adjust and mark in red on die
 Adjust and make reduction coping
 Do not adjust make as is

IF BAD IMPRESSION SENT

 Do best you can to process
 Contact for discussion

REMAKE INFORMATION

(Please complete this section if returning this case for a remake)

Customer Original Pan # _____ PLS Original RX # _____

Reason for Remake _____

Items being Returned

<input type="checkbox"/> Original Prosthesis (Crown, Partial, Bite, Etc.)	<input type="checkbox"/> Original Model	<input type="checkbox"/> Original Die	<input type="checkbox"/> Original PLS RX
<input type="checkbox"/> Old Impression	<input type="checkbox"/> New Impression	<input type="checkbox"/> Study Model	

(Failure to provide original RX, reason, or items may result in a delay in processing this case and a charge for this remake)

OTHER SPECIAL INSTRUCTIONS



Customer Information Sheet

Comment/Special instructions

Customer Information

Full Name of Lab:

Email:

Address:

Street Address

Unit #

City

State

ZIP Code

Business Phone: _____

Cell Phone

Website: _____

Bill to address:

[if different from above]:

Shipping Address

[if different from above]:

Address:

Street Address

Unit #

City

State

ZIP Code

Business Phone: _____

Key Contact

Technical Contact

Title

Phone

Email

Accounting Contact

Title

Phone

Email

Alternate Contact

Title

Phone

Email

General Information [please answer all questions]

Briefly describe company/agency's primary endeavors: _____

How did you first hear about us? _____

