



| |
|------------|
| Date Rx In |
| Date Due |

Delivered by Spm

Doctor _____ (please print)

Address _____

Patient Name _____ Sex M F Age _____

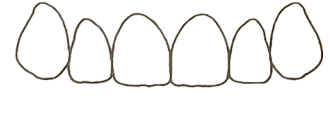
FIXED RESTORATIONS PLEASE

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Non-Precious | <input type="checkbox"/> Full Cast Yellow Gold | <input type="checkbox"/> Argen Z Anterior | <input type="checkbox"/> BruxZir |
| <input type="checkbox"/> Semi-Precious | <input type="checkbox"/> Full cast White Gold | <input type="checkbox"/> E.Max | <input type="checkbox"/> BruxZir Anterior |
| <input type="checkbox"/> High Noble | <input type="checkbox"/> Full Cast Non-Precious | <input type="checkbox"/> Veneer | <input type="checkbox"/> Cercon HT |
| <input type="checkbox"/> Captak | <input type="checkbox"/> Full Cast Semi-Precious | <input type="checkbox"/> In(on) Lay | <input type="checkbox"/> Katana ML |
| | | <input type="checkbox"/> Porecelain Fused To Zirconia (PFZ) | |

- Anteriors**
- Metal Coping
- Metal Lingual
- 3/4 Metal Lingual

- Posteriors**
- Metal Coping
All Porcelain Coverage
- Metal Lingual
Excluding Buccal Cusp
- 3/4 Metal Lingual
Including Buccal Cu:

- Buccal Margin**
- Metal Margin
Hairline or ____ mm
- Porcelain Margin



Shade _____

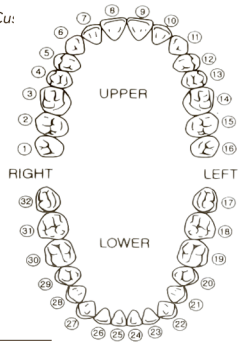
Please Send

Rx Forms Boxes Mailing Labels

Enclosures (lab use only)

Photos Analog Models Implant Parts

Impression Bite Shade Tab Other _____



REMOVABLE RESTORATIONS PLEASE

- Dentures**
- Custom Tray
- Base Plate / Wax Rim
- Combo Tray / Wax Rim
- Economy Denture
- Premium Denture
- Immediate Denture
- Denture Set Up
- Denture Finish

- Repairs / Relines**
- Hard Soft
- Tooth Fractures
- Clasp

- Metal Partials**
- Standard Partial
- DeLuxe Partial (Vitalium 2000)
- Frame Try-In
Wax Try-In w/ Teeth
- Bite Block
- Finish

- Flexible Partials**
- Valplast™
- TCS
- Set-Up
- Finish

- Specialty Partials**
- Acrylic Partial Flipper
- Acrylic Partial w/ Clasp
- Unilateral (NESBIT)

- Shade**
- Dark Pink
- Standard (Pink) Meharry
- Meharry
- Dark Medium

Tooth Shade _____

Tooth Mold _____

Tooth Make _____

Rx Specific Instructions:

Dr. Signature _____ License # _____