

FINISH	Date _____	AM PM
Metal Try-In	Date _____	AM PM
Bisque Try-In	Date _____	AM PM

Dr. _____ Date _____
 Address _____
 Phone _____ Patient _____
 Sex _____ Age _____ PAN #: _____ *(assigned by lab)*

ADVANCED DENTAL RESTORATIVE SYSTEMS

TYPE OF RESTORATION

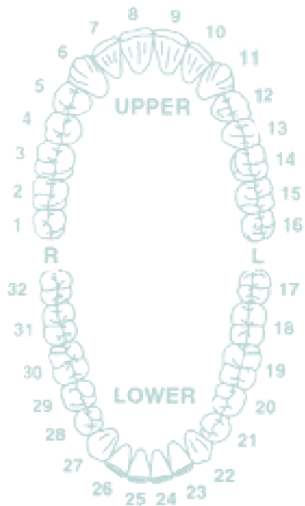
- Porcelain Fused-to-Metal
- IPS Empress, Authentic
- E-Max
- YZ, Lava, Milled Zirconia
- Implant Other _____
- Diagnostic Wax-up
- Full Gold Crown
- Composite
- Custom Temps

Shade: _____
 Stumpshade: _____

INCLUDED IN PAN

- Implant Analog
- Implant Abutment
- Bite
- Old Crown

RX INSTRUCTIONS:



TYPE OF METAL

- High Noble (Yellow)
- High Noble (White)
- Noble (Semi-precious)
- 24 karat (Bio)

METAL DESIGN

Margins

- Porcelain Butt Margin (Shoulder Prep Required)
- Porcelain to Margin (Feather Margin)
- Lingual Collar _____mm
- Full Metal Band _____mm
- Other _____

Metal Occlusal

- Excluding Buccal Cusp
- Including Buccal Cusp
- Metal Lingual _____mm

COSMETIC SYSTEMS

PHOTOS:

- Pre-Op Photo
- Preps with Stump Shade
- Temps - Full Face
- Temps - Nose to Chin (Relaxed Lip)
- Stick Bite - Full Face
- Profile

INCLUDED IN PAN:

- Pre-Op Models
- Wax-up
- Diagnostic
- Final Impression
- Stick Bite
- Face bow
- Opposing
- Impression of Temps

Please indicate desired shade on drawing below:



LENGTH			
Central _____mm	Lateral _____mm	Canine _____mm	

- | | | | | |
|----------------------|--------------------------------|------------------------------|--------------------------------|-------------------------------|
| Incisal Translucency | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |
| Mamallons | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |
| Surface Texture | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |
| Occlusal Staining | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |

Dr. Signature _____

License Number: _____