

Type of Fixed Restoration

- | | |
|-------------------------------|---|
| <input type="checkbox"/> PFM | <input type="checkbox"/> Gold Inlay/Onlay |
| <input type="checkbox"/> FGC | <input type="checkbox"/> Procera Alumina |
| <input type="checkbox"/> EMAX | <input type="checkbox"/> Procera Zirconia |
| <input type="checkbox"/> Lava | <input type="checkbox"/> Milled Full Contour Zirconia |



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www.seattledentalarts.com

____/____/____
Today's Date**Type of Metal**

- | | |
|--|---|
| <input type="checkbox"/> High Noble (Precious) | <input type="checkbox"/> Yellow Ceramic |
| <input type="checkbox"/> Noble (Semi-Precious) | <input type="checkbox"/> Type II |
| <input type="checkbox"/> Base (Non-Precious) | <input type="checkbox"/> Type III |

Type of Occlusal Surface

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> All Porcelain | <input type="checkbox"/> 2/3 Metal |
| <input type="checkbox"/> Metal Island | <input type="checkbox"/> Full Metal |

Type of Buccal Margin

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Porc Shoulder (Butt) | <input type="checkbox"/> Metal ____mm |
| <input type="checkbox"/> Porcelain | |

Type of Lingual Margin

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Porcelain | <input type="checkbox"/> Metal ____mm |
|------------------------------------|---------------------------------------|

Diagnostic

- | | |
|---|--|
| <input type="checkbox"/> Wax-Up | <input type="checkbox"/> Presurgical Stint |
| <input type="checkbox"/> Duplicate Models | <input type="checkbox"/> Custom Tray |
| <input type="checkbox"/> Vacuum Form Temp Matrix | |
| <input type="checkbox"/> Mount on Semi-Adjustable Articulator | |

☐ Male ☐ FemaleAge: ☐ Youth ☐ Middle ☐ Senior

Shade _____

☐ Lab To Take Custom Shade**Implant Abutment**☐ Titanium ☐ Zirconia**Placement Jig**☐ Yes ☐ No**Night Guards**☐ Upper☐ Lower☐ Hard☐ Resilient☐ Dual

RX Instructions:

License No. _____

Date(s) and Time(s) of Delivery

Try-InFinal Seat

Date _____

Date _____

Time _____

Time _____

Doctor's Name and Address

Signature _____

Address _____

Phone _____