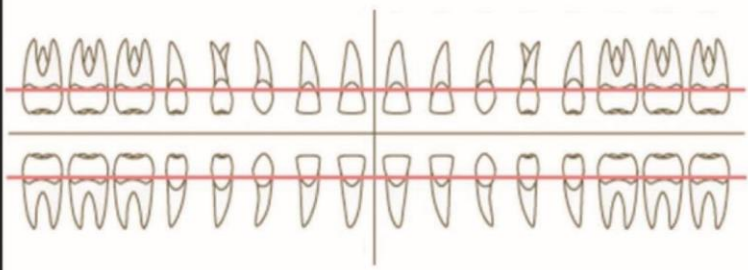

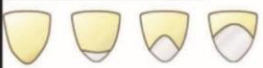






Doctor's Name: _____ Patient: _____

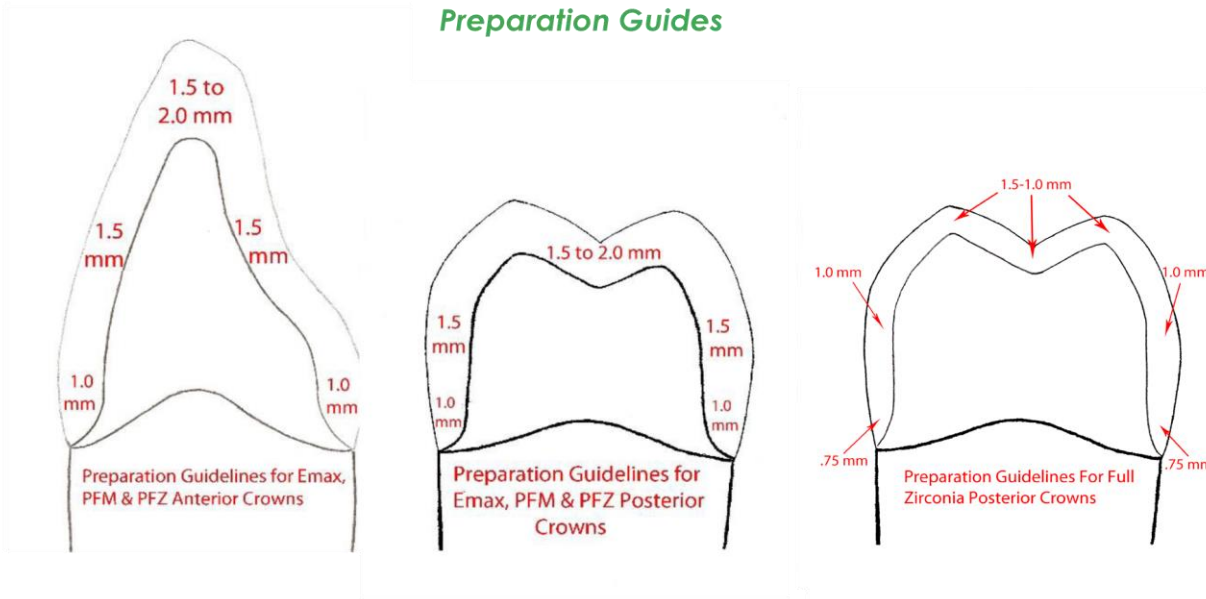
Address: _____ Patient Appt Date & Time: _____

Phone #: _____ Dr's Signature: _____

<p>Porcelain Fused to:</p> <p><input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> High-Precious</p> <p>All Ceramic Restorations:</p> <p><input type="checkbox"/> IPS e.max <input type="checkbox"/> Zirconia PFZ <input type="checkbox"/> Full Contour Zirconia</p> <p>Full Cast Restorations:</p> <p><input type="checkbox"/> Non-Precious <input type="checkbox"/> Semi-Precious <input type="checkbox"/> High-Precious</p> <p>Implants:</p> <p><input type="checkbox"/> Screw Retained <input type="checkbox"/> Cementable <input type="checkbox"/> Zirconia Abutment <input type="checkbox"/> Titanium Abutment</p> <p>Type: _____</p> <p>Diameter: _____</p> <p>Miscellaneous:</p> <p><input type="checkbox"/> Temp Crown <input type="checkbox"/> Metal Occlusion <input type="checkbox"/> Porcelain Butt Margin <input type="checkbox"/> Rest <input type="checkbox"/> Diagnostic Wax Up <input type="checkbox"/> Composite Crown <input type="checkbox"/> Locator <input type="checkbox"/> Attachment (ERA) <input type="checkbox"/> Locator <input type="checkbox"/> Telescope <input type="checkbox"/> Implant Bar <input type="checkbox"/> Cast Implant Abut (UCLA)</p>	<p>Tooth Number:</p> <p>Abutment _____ Maryland Wing _____</p> <p>Crown _____ Pontic _____</p> <p>Inlay _____ Onlay _____</p> <p>Veneer _____ Post _____</p>  <p>Basic Shade: <input type="checkbox"/> Custom Shade Design: <input type="checkbox"/> Shade Guide Used _____</p>  <p>Margin Design:</p> <p><input type="checkbox"/> No Metal Collar <input type="checkbox"/> 180 Metal Collar <input type="checkbox"/> 360 Metal Collar</p> <p>Anterior Design:  Posterior Design: </p> <p>Pontic Design: </p> <p>Occlusal Clearance: <input type="checkbox"/> Light <input type="checkbox"/> Tight <input type="checkbox"/> Open</p> <p>Contacts: <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy</p> <p>Occlusal Stain: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy</p> <p>If Insufficient Room: (must select)</p> <p><input type="checkbox"/> Reduce Opposing <input type="checkbox"/> Place metal Island/Occ <input type="checkbox"/> Reduction Coping</p>	<p>Removable Prosthetics:</p> <p><input type="checkbox"/> UPPER <input type="checkbox"/> LOWER</p> <p>Tooth Shade: _____</p> <p>Partial Denture:</p> <p>Type of Material:</p> <p><input type="checkbox"/> Valplast <input type="checkbox"/> Cr Co <input type="checkbox"/> Acrylic</p> <p><input type="checkbox"/> Framework only <input type="checkbox"/> Set Teeth Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Complete (without Try-in)</p> <p>Type of Denture:</p> <p><input type="checkbox"/> Medical Card <input type="checkbox"/> Private Denture</p> <p>Full or Partial</p> <p><input type="checkbox"/> Wax Try-in <input type="checkbox"/> Finish <input type="checkbox"/> Complete (Without Try-in) <input type="checkbox"/> Acrylic (Immediate) Denture</p> <p>Removable Extras:</p> <p><input type="checkbox"/> Bite Rims <input type="checkbox"/> Custom Trays <input type="checkbox"/> Rebase <input type="checkbox"/> Repair <input type="checkbox"/> Reline <input type="checkbox"/> Add Valplast Clasp <input type="checkbox"/> Add Clear Clasp <input type="checkbox"/> Add Cast Clasp <input type="checkbox"/> Add Ball Clasp <input type="checkbox"/> Upper Michigan <input type="checkbox"/> Lower Tanner Splint</p>
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TRS Dental guarantees that this custom made device was made exclusively for the patient named on this lab prescription sheet. This custom made device conforms to the requirements set out in Annex 1 of the MDD 93/42/EEC.

Preparation Guides



Doctor Notes
