WEB DL

DATE _____

DR. _____

PT. _____

AGE _____ Male / Female

DATE REQUIRED _____

TEETH TO BE RESTORED

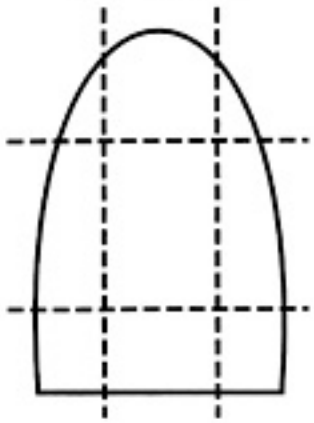
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Request Call After Mounting? ☐ YES ☐ NO

Please Check Desired Mounting

☐ HIP
☐ FACE BOW
☐ STICK BITE
☐ STRATOS
☐ ACCULINER
☐ OTHER _____

Color Mapping



ITEMS RECEIVED

___ Base Model
___ Bite
___ Contact Model
___ Crowns
___ Diagnostic Wax Up
___ Implant Parts
___ Impression
___ Matrix
___ Opposing Model
___ Partial
___ Photos
___ Study Model
___ Other

CHARACTERIZATION CHART

Value
☐ High (bright)
☐ Medium
☐ Low

Shade _____

Length of Centrals _____mm

Hypo-Calcification _____

Posterior Occlusal Characterization _____

IPS e.max
Bonding ONLY
☐ Crown
☐ Veneer
☐ Inlay/Onlay
☐ Stump Shade

Porcelain to Metal
☐ Full Coverage
☐ Metal Occlusal
☐ Porcelain Shoulder
☐ Porcelain Shoulder
☐ Labial Metal Collar
☐ Lingual Metal Collar
☐ No Metal Collar

Composite
☐ Inlay
☐ Onlay

☐ Diagnostic Wax Up
☐ Orthotic

Orthotic
☐ Removable
☐ Fixed

Other Appliance_____

Dr. Signature _____

License Number _____

Address _____

Telephone _____

SPECIAL INSTRUCTIONS: _____

DENTAL CERAMICS, INC.
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