TRIAL SMILE RX

Please complete and enclose with case.

DOCTOR: _____ **DATE:** _____

ADDRESS: _____ **PHONE:** (_____) _____

CITY: _____

STATE: _____ **ZIP:** _____

PATIENT NAME: _____ **AGE:** _____

DATE DUE BACK IN OFFICE: _____

The following information, along with photos and detailed impressions/study models or scans of the teeth and gingiva will aid us in working as a team to create an ideal, functional, and esthetic diagnostic blueprint for this patient.

1) Main objective(s) of the treatment: (shade change, improve smile, align teeth, etc.)

_____

_____

_____

_____

_____

2) 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

3) Possible Additional Procedures:

- ☐ Orthodontics _____
- ☐ Implants _____
- ☐ Tissue Grafting _____
- ☐ Crown Lengthening _____
- ☐ Extractions _____
- ☐ Other _____

Doctor's Signature _____

Doctor's License Number _____