



ORDER FORM

Dentist: _____

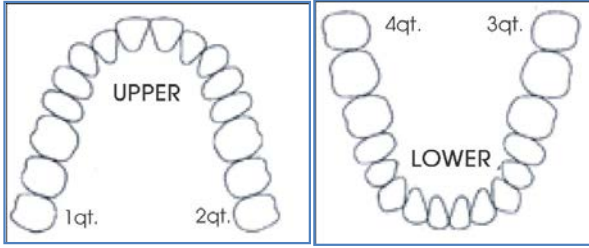
Order Date: _____

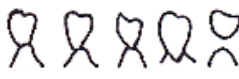

Patient: _____


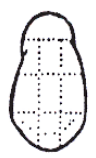
Return Date: _____

Gender: Male Female Age: _____

Time: _____

Work Type																																																																		
Fixed Work	Removable Work																																																																	
<input type="checkbox"/> Porcelain Fused to Metal (PFM) <input type="checkbox"/> Full Metal Crown (FMC) crown / inlay / onlay <input type="checkbox"/> Mary land bridge <input type="checkbox"/> Implant (most common systems) **SENT NECESSARY ABUTMENTS** <input type="checkbox"/> Stiff crown (crown with pin) <input type="checkbox"/> Post & Core <input type="checkbox"/> Inlay / onlay <u>Ceramic work</u> <input type="checkbox"/> IPS-emax crown / inlay / onlay / veneer <input type="checkbox"/> Zirconium crown <input type="checkbox"/> Zirconium bridge	<input type="checkbox"/> Partial Frame (only metal frame) <input type="checkbox"/> Partial denture framework <input type="checkbox"/> Acrylic Denture <input type="checkbox"/> Full Denture <input type="checkbox"/> Valpast / Vitaflex <input type="checkbox"/> Nightguard <input type="checkbox"/> Sportguard / Mouthguard <input type="checkbox"/> Splint <input type="checkbox"/> Others _____	<table border="1" style="border-collapse: collapse; width: 100%; text-align: center;"> <tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr> <tr><td>18</td><td>17</td><td>16</td><td>15</td><td>14</td><td>13</td><td>12</td><td>11</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr> <tr><td>48</td><td>47</td><td>46</td><td>45</td><td>44</td><td>43</td><td>42</td><td>41</td><td>31</td><td>32</td><td>33</td><td>34</td><td>35</td><td>36</td><td>37</td><td>38</td></tr> <tr><td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td></tr> </table>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
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32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17																																																			

Alloy	Margin Design	Metal Design
<input type="checkbox"/> Non Precious <input type="checkbox"/> Semi Precious <input type="checkbox"/> Yellow <input type="checkbox"/> White <input type="checkbox"/> High Precious <input type="checkbox"/> Yellow <input type="checkbox"/> White	<input type="checkbox"/> No metal margin <input type="checkbox"/> Buccal metal margin _____ mm. <input type="checkbox"/> Lingual metal margin _____ mm. <input type="checkbox"/> Occlusal metal <input type="checkbox"/> Metal / distal _____ mm. <input type="checkbox"/> Porcelain margin (only if shoulder prepared)	<u>Pontics:</u>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <u>Metal Coping Lingual</u>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Shade		
 <p>Translucent _____ Vita Shade _____ Cervical Staining: <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<u>Fissur Staining (surface)</u> <input type="checkbox"/> no <input type="checkbox"/> light <input type="checkbox"/> medium <input type="checkbox"/> heavy	<u>Occlusal Staining</u> <input type="checkbox"/> no <input type="checkbox"/> light <input type="checkbox"/> medium <input type="checkbox"/> heavy

INSTRUCTIONS:

Enclosed:	
<input type="checkbox"/> working model <input type="checkbox"/> study model <input type="checkbox"/> shade <input type="checkbox"/> imprint / tray <input type="checkbox"/> bite <input type="checkbox"/> photo <input type="checkbox"/> die <input type="checkbox"/> articulator <input type="checkbox"/> others _____	