

Doctor Name _____ Patient Name _____ Remake Reason (if applicable) _____
Last First Last First
 Practice Name _____ Patient Chart # _____ M F
Last First
 Full Address _____ Rx Date _____ Due Date/Delivery on _____
 Phone _____ **Rush Case** (fee applies) Is this case a Remake? Yes No
 Tooth Shade _____ Shade Guide _____
(Required) (Vita is default)
 Stump Shade _____ Pink Tissue Shade _____
(Required for E.MAX)

Crown & Bridge Rx

Complete the left side of the Rx, where applicable, for fixed cases.

Please **CIRCLE** single units and **BRACKET** splinted units

| | | | | | | | | | | | | | | | |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 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 |

| | | | |
|--|--|---|---|
| All Ceramic <input type="checkbox"/> Solid Zirconia** (posterior) <input type="checkbox"/> High Translucent** (anterior) <input type="checkbox"/> Lithium Disilicate | <input type="checkbox"/> Solid lingual w Porcelain facial <input type="checkbox"/> Layered Zirconia <input type="checkbox"/> IPS Emax <input type="checkbox"/> Diagnostic Wax Up <input type="checkbox"/> Temporary PMMA | PFM <input type="checkbox"/> High Noble White** <input type="checkbox"/> High Noble Yellow <input type="checkbox"/> Noble/Semi Precious <input type="checkbox"/> Base/Non-precious | Full Cast <input type="checkbox"/> High Noble White <input type="checkbox"/> High Noble Yellow** <input type="checkbox"/> Noble/Semi Precious <input type="checkbox"/> Base/Non-precious <input type="checkbox"/> FC Noble 2% |
|--|--|---|---|

MARGIN DESIGN
Please circle your choice(s) of margin combination

| | | | | | | |
|---------------------|-----------------------------|-------------------|--------------------------------|------------------------------------|----------------|---------------|
| | | | | | | |
| Show no metal 360°* | All porcelain shoulder 360° | Metal collar 360° | Facial porcelain shoulder 180° | Lingual metal collar (traditional) | Metal occlusal | Metal lingual |

CROWN DESIGN

Characterization

Pontic Design
 Modified ridge-lap
 Saddle ridge-lap
 Sanitary/hygienic
 Conical
 Ovate

IF INSUFFICIENT ROOM

Trim opposing**
 Call to discuss
 Metal occlusal
 Reduction coping
 Resin**
 Metal
 Metal island
 Trim prep no coping

OCCUSAL CONTACT

Light**
 Open
 Tight

INTERPROXIMAL CONTACT

Light**
 Medium
 Heavy

Return for

Finish**
 Die trim
 Bisque
 Metal try-in

Restoration

Crown
 Bridge
 No-prep veneer
 Veneer
 Inlay/Onlay
 Implant
 Post & Core

Rest Seats (specify): _____

Crown under partial (specify): _____

To request supplies, email: customerservice@ddslab.com

5440 Beaumont Center Blvd, Suite 400, Tampa, Florida 33634 (877) 337-7800

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Please provide a bite and an opposing with the case. Email photos to: ddslabpix@ddslab.com

*The person signing this form is an authorized signer and, along with the dental practice, accepts responsibility for payment of all related charges, as well as any legal costs, collection and other fees incurred by DDS Lab in the event the account is sent to collections or litigation.

**Default material if an option is not selected

Removable Prosthetics Rx

Complete the right side of the Rx, where applicable, for removable cases.

Choose Case Type

Full Denture Partial Unilateral**
 Immediate Denture Immediate Partial Flipper

Choose Arch

Upper Lower
 Both

Teeth Type

Elite**
 Premier (Fee applies)

Choose Stage

Custom Tray
 Cast Metal Framework
 Base Plate
 Occlusal Rim
 Try In**
 Finish
 Repair
 Reline
 Rebase

Choose Material

Acrylic**
 Metal
 CustomFlex Partial
 Valplast Partial
 Chrome Cobalt**
 Vitallium

Add On

Patient ID
 Cosmetic Clasp
 Wire Mesh
 Wire reinforcement
 Metal mesh
 Soft liner

Acrylic Shade

Lucitone 199**
 Light Meharry
 Light Pink
 Meharry

Nightguard

Upper** Flexiguard (hard/soft)**
 Lower Hard Soft

Partial Design

Horseshoe palate (upper)
 Full palatal metal coverage (upper)
 A-P strap (upper)
 Lingual bar (lower)
 Lingual apron

Extract Now

Yes No

Dentist Signature _____ (Required)

Dentist License # _____ (Required)

Rx Specific Instructions _____