

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

## Crown & Bridge Rx

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

## Removable Prosthetics Rx

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

<b>All Ceramic</b> <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	<b>PFM</b> <input type="checkbox"/> High Noble White** <input type="checkbox"/> High Noble Yellow <input type="checkbox"/> Noble/Semi Precious <input type="checkbox"/> Base/Non-precious	<b>Full Cast</b> <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%
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### 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

<b>IF INSUFFICIENT ROOM</b> <input type="checkbox"/> Trim opposing** <input type="checkbox"/> Call to discuss <input type="checkbox"/> Metal occlusal <input type="checkbox"/> Reduction coping <input type="checkbox"/> Resin** <input type="checkbox"/> Metal <input type="checkbox"/> Metal island <input type="checkbox"/> Trim prep no coping	<b>OCCUSAL CONTACT</b> <input type="checkbox"/> Light** <input type="checkbox"/> Open <input type="checkbox"/> Tight  <b>INTERPROXIMAL CONTACT</b> <input type="checkbox"/> Light** <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
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<b>Return for</b> <input type="checkbox"/> Finish** <input type="checkbox"/> Die trim <input type="checkbox"/> Bisque <input type="checkbox"/> Metal try-in  <input type="checkbox"/> Rest Seats (specify): _____ <input type="checkbox"/> Crown under partial (specify): _____	<b>Restoration</b> <input type="checkbox"/> Crown <input type="checkbox"/> Veneer <input type="checkbox"/> Bridge <input type="checkbox"/> Inlay/Onlay <input type="checkbox"/> No-prep veneer <input type="checkbox"/> Implant <input type="checkbox"/> Post & Core
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<b>Choose Case Type</b> <input type="checkbox"/> Full Denture <input type="checkbox"/> Partial <input type="checkbox"/> Unilateral <input type="checkbox"/> Immediate <input type="checkbox"/> Flipper	<b>Choose Arch</b> <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both	<b>Teeth Type</b> <input type="checkbox"/> Elite** <input type="checkbox"/> Premier <small>(Fee applies)</small>
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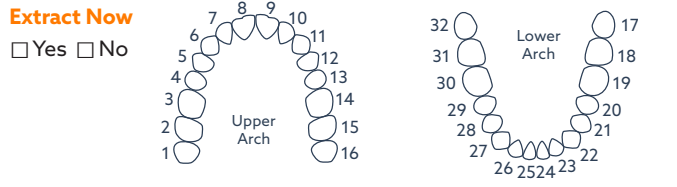
<b>Choose Stage</b> <input type="checkbox"/> Custom Tray <input type="checkbox"/> Cast Metal Framework <input type="checkbox"/> Base Plate <input type="checkbox"/> Occlusal Rim <input type="checkbox"/> Try In** <input type="checkbox"/> Finish <input type="checkbox"/> Repair <input type="checkbox"/> Reline <input type="checkbox"/> Rebase	<b>Choose Material</b> <input type="checkbox"/> Acrylic** <input type="checkbox"/> Metal <input type="checkbox"/> CustomFlex Partial <input type="checkbox"/> Valplast Partial <input type="checkbox"/> Chrome Cobalt** <input type="checkbox"/> Vitallium	<b>Add On</b> <input type="checkbox"/> Patient ID <input type="checkbox"/> Cosmetic Clasp <input type="checkbox"/> Wire Mesh <input type="checkbox"/> Wire reinforcement <input type="checkbox"/> Metal mesh <input type="checkbox"/> Soft liner	<b>Acrylic Shade</b> <input type="checkbox"/> Lucitone 199** <input type="checkbox"/> Light Meharry <input type="checkbox"/> Light Pink <input type="checkbox"/> Meharry
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### Nightguard

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

### Partial Design

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



Dentist Signature \_\_\_\_\_  
(Required)

Dentist License # \_\_\_\_\_  
(Required)

Rx Specific Instructions \_\_\_\_\_