DENTAL CERAMICS LTD

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DATE _____

DR. _____

PATIENT _____

DUE DATE _____

TEETH TO BE RESTORED

01 02 03 04 05 06 07 08 09 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 CASE YES ○ NO ◉

PORCELAIN TO METAL

- ☐ FULL COVERAGE
- ☐ METAL OCCLUSAL
- ☐ PORCELAIN MARGIN FACIAL
- ☐ PORCELAIN MARGIN FULL
- ☐ CERVICAL METAL COLLAR LABIAL
- ☐ LINGUAL METAL COLLAR (DEFAULT)
- ☐ NO METAL COLLAR

ALL CERAMIC

- ☐ IPS e.max
- ☐ e.max PLUS
- ☐ LAMINATE
- ☐ DIAGNOSTIC WAX UP

FULL CAST

- ☐ CROWN
- ☐ INLAY
- ☐ ONLAY

ITEMS RECEIVED

- ☐ WORKING MODEL(S)
- ☐ BITE
- ☐ OLD CROWNS
- ☐ DIAGNOSTIX WAX UP
- ☐ SHADE TAB
- ☐ IMPLANTS PARTS
- ☐ IMPRESSION
- ☐ OPPOSING MODEL
- ☐ PARTIAL
- ☐ PHOTOGRAPHS
- ☐ STUDY CASTS
- ☐ ARTICULATOR
- ☐ OTHER

Rx

SHADE INFORMATION

SPECIAL INSTRUCTIONS

DR. SIGNATURE _____

LICENSE NUMBER _____

ADDRESS _____

TELEPHONE _____

DENTAL CERAMICS LTD, INC.
4520 NORTHWESTERN DRIVE, ZIONSVILLE IN, 46077 | 317.876.3100 | 800.423.4660 | info@dentalceramicsltd.com