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
- ☐ ZIRCONIA

FULL CAST

- ☐ CROWN
- ☐ INLAY
- ☐ ONLAY

IMPLANT

- ☐ SCREW RETAINED
- ☐ ABUTMENT SEPARATE CROWN

DR. SIGNATURE _____

LICENSE NUMBER _____

ADDRESS _____

TELEPHONE _____

ITEMS RECEIVED

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

SHADE INFORMATION

SPECIAL INSTRUCTIONS

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