

DOCTOR _____ DATE _____

ADDRESS _____ AGE _____

PATIENT _____ M ☐ F ☐

DUE DATE:	TIME:
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INSTRUCTION: _____

TYPE OF RESTORATION

- ☐ PFM ☐ E-MAX
☐ FULL METAL ☐ EMPRESS/VEENER
☐ IMPLANT ☐ ZIRCONIA
☐ POST/CORE

TYPE OF MARGIN

- ☐ PORCELAIN BUTT MARGIN
☐ FINE METAL COLLAR - 0.5MM
☐ COMBINATION MARGIN
☐ HEAVY METAL COLLAR - 1.0MM

TYPE OF METAL

- ☐ HIGH NOBLE
☐ NOBLE
☐ YELLOW
☐ WHITE

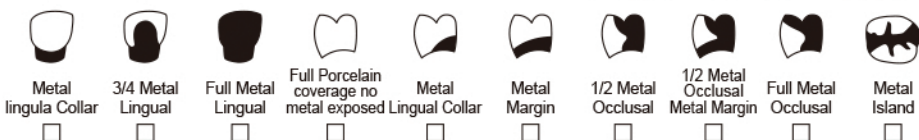
OCCLUSAL CONTACT

- ☐ POSITIVE
☐ FOIL RELIEF
☐ # OF FOIL

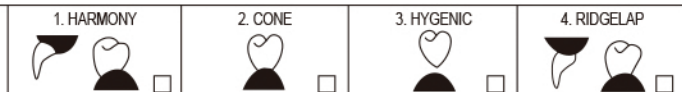
TYPE OF OCCLUSION

- ☐ METAL ☐ CUSPID GUIDANCE
☐ PORCELAIN ☐ GROUP FUNCTION

CONTACTS



PONTIC DESIGN



SHADE

CUSTOM SHADE



Doctor's Signature - required
(CDSBC Article 21)

