

<b>FINISH</b>	Date _____	AM PM
<b>Metal Try-In</b>	Date _____	AM PM
<b>Bisque Try-In</b>	Date _____	AM PM

Dr. \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Patient \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ PAN #: \_\_\_\_\_ *(assigned by lab)*

**ADVANCED DENTAL RESTORATIVE SYSTEMS**

**TYPE OF RESTORATION**

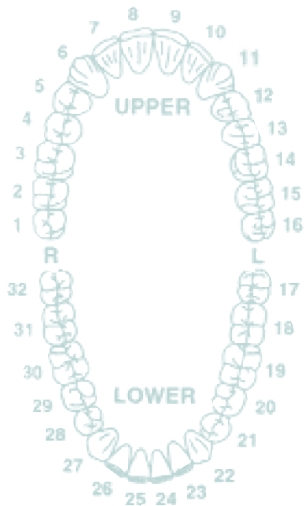
- Porcelain Fused-to-Metal
- IPS Empress, Authentic
- E-Max
- YZ, Lava, Milled Zirconia
- Implant  Other \_\_\_\_\_
- Diagnostic Wax-up
- Full Gold Crown
- Composite
- Custom Temps

Shade: \_\_\_\_\_  
 Stumpshade: \_\_\_\_\_

**INCLUDED IN PAN**

- Implant Analog
- Implant Abutment
- Bite
- Old Crown

**RX INSTRUCTIONS:**



**TYPE OF METAL**

- High Noble (Yellow)
- High Noble (White)
- Noble (Semi-precious)
- 24 karat (Bio)

**METAL DESIGN**

*Margins*

- Porcelain Butt Margin (Shoulder Prep Required)
- Porcelain to Margin (Feather Margin)
- Lingual Collar \_\_\_\_\_mm
- Full Metal Band \_\_\_\_\_mm
- Other \_\_\_\_\_

*Metal Occlusal*

- Excluding Buccal Cusp
- Including Buccal Cusp
- Metal Lingual \_\_\_\_\_mm

**COSMETIC SYSTEMS**

**PHOTOS:**

- Pre-Op Photo
- Preps with Stump Shade
- Temps - Full Face
- Temps - Nose to Chin (Relaxed Lip)
- Stick Bite - Full Face
- Profile

**INCLUDED IN PAN:**

- Pre-Op Models
- Wax-up
- Diagnostic
- Final Impression
- Stick Bite
- Face bow
- Opposing
- Impression of Temps

Please indicate desired shade on drawing below:



<b>LENGTH</b>			
Central _____mm	Lateral _____mm	Canine _____mm	

- |                      |                                |                              |                                |                               |
|----------------------|--------------------------------|------------------------------|--------------------------------|-------------------------------|
| Incisal Translucency | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |
| Mamallons            | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |
| Surface Texture      | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |
| Occlusal Staining    | <input type="checkbox"/> Heavy | <input type="checkbox"/> Med | <input type="checkbox"/> Light | <input type="checkbox"/> None |

Dr. Signature \_\_\_\_\_

License Number: \_\_\_\_\_