



# Doctor's Preference Profile

(Return with first case)\*

Date: \_\_\_\_\_

## Office Information (please be as complete as possible)

Doctor: \_\_\_\_\_  
 Practice Name (if different): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Email: \_\_\_\_\_

### Office Phone Numbers

Main #: \_\_\_\_\_  
 Fax #: \_\_\_\_\_  
 "Back-line" #: \_\_\_\_\_  
 Dr. Cell Phone: \_\_\_\_\_  
 Other: \_\_\_\_\_

How do you prefer to be contacted?  Office phone  Cell  Text  Email  Other \_\_\_\_\_

I would like my statements and invoices emailed to me:  No  Yes (email) \_\_\_\_\_

### Additional Team Members

### Names

Receptionist \_\_\_\_\_

Assistant #1 \_\_\_\_\_

Other Important Team Members \_\_\_\_\_

Crown & Bridge	Options (those in bold are our standards)
Alloy Choice <i>Porcelain Alloy</i> <i>Full Cast Alloy</i>	<input type="checkbox"/> High Noble White <input type="checkbox"/> High Noble Yellow <input type="checkbox"/> Noble White <input type="checkbox"/> Base <input type="checkbox"/> High Noble Gold <input type="checkbox"/> Noble Gold <input type="checkbox"/> Noble White <input type="checkbox"/> Base
Proximal Contact	<input type="checkbox"/> Broad <input type="checkbox"/> Natural <input type="checkbox"/> Heavy
Occlusion	<input type="checkbox"/> Classic occlusion (holds shimstock) <input type="checkbox"/> <b>Slightly out of occlusion</b> (shimstock pulls thro) <input type="checkbox"/> Out of occlusion (1 layer of foil) <input type="checkbox"/> Out of occlusion (2 layers of foil)
Room Issue	<input type="checkbox"/> Do not relieve, return for re-prep <input type="checkbox"/> Relieve Opposing <input type="checkbox"/> Relieve Die <input type="checkbox"/> Call for instructions
Occlusal Staining	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Cervical Staining	<input type="checkbox"/> Yes <input type="checkbox"/> No
Solid Model	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pontic Design	<input type="checkbox"/> Full Ridge-lap <input type="checkbox"/> Hygienic <input type="checkbox"/> <b>Modified Ridge-lap</b> <input type="checkbox"/> Ovate
Ridge Relief	<input type="checkbox"/> None <input type="checkbox"/> <b>Slight</b> <input type="checkbox"/> Medium <input type="checkbox"/> Heavy
Die Spacer	<input type="checkbox"/> Standard 2 layers <input type="checkbox"/> None <input type="checkbox"/> # of coats
Esthetic Upgrade	<input type="checkbox"/> Capella
Mini Implant Gingival Design	<input type="checkbox"/> No ridge lap <input type="checkbox"/> Buccal ridge lap <input type="checkbox"/> Lingual ridge lap <input type="checkbox"/> <b>360° ridge lap</b>

Denture	Options (those in bold are our standards)
Partial Denture Standards	<input type="checkbox"/> <b>Premium</b> <input type="checkbox"/> Economy
Alloy	<input type="checkbox"/> <b>Wironium</b> <input type="checkbox"/> Vitallium
Flexible Partial	<input type="checkbox"/> <b>E-FLX</b> <input type="checkbox"/> Valplast <input type="checkbox"/> Flexite
Manufacturer's Tooth Preference	<input type="checkbox"/> Dentsply <input type="checkbox"/> Ivoclar Vivodent
Name in Denture	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No    (MO dentists are required by law to include name)

**Please specify additional options on your lab prescription form.**