

Dr. _____ Date: _____

Address: _____

City: _____ State: _____

Phone: _____ Zip: _____

Patient: _____ Age: _____

Male Female

Request Return Date: _____ Time: _____

[sig-na-ture]

Are you a Signature Account?

Yes No

ENCLOSED WITH CASE

Impression Master Model Opposing Model Bite Relation

Study Model Diag. Wax-up Shade Tab Photo

Denture Partial Old Crown Articulator

Facebow Attachment Implant Components

Digital Scan: Date Sent: _____ Time Sent: _____

System: _____

Special Instructions:

Please call Please Text: # _____

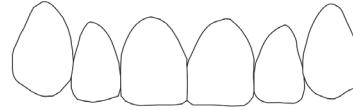
Has this case been disinfected? Yes No



Made in the U.S.A.

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CERAMIC SHADE INSTRUCTIONS



SHADE GUIDE USED

Vita Classic Chromoscope

Vita 3-D Other: _____

Final Shade: _____ Stump Shade: _____

Non Vital Shade: _____

Photos sent to photos@EDPLabs.com Yes No

Date Sent: _____

SURFACE TEXTURE

Smooth Moderate Heavy

OCCUSAL STAINING

None* Light Medium Heavy

PONTIC DESIGN

High Water Hygenic Modified Ridge Lap

Full Ridge Lap Ovate

RIDGE RELIEF

None Slight Medium Heavy

FACIAL MARGIN DESIGN

Metal-porcelain junction margin *
 Metal hairline or _____ mm on buccal
 Porcelain butt margin (90° shoulder required)

METAL DESIGN

Coping with full porcelain coverage*
 Metal lingual collar with porcelain coverage
 Metal occlusal **excluding** buccal cusp
 Metal occlusal **including** buccal cusp

*Standard unless otherwise specified

CROWN & BRIDGE / CERAMICS

PORCELAIN TO METAL

Alloy

High Noble Yellow Noble White
 High Noble White Base Metal

ALL CERAMIC

IPS e.max LiSi
 CerEnamel Veneer

ZIRCONIA

E-Zr™ Total E-Zr™ Layered
 E-Zr™ Natural E-Zr™ Veneer

Upgrade my Restorations to

Capella Yes

FULL CAST

High Noble Gold Noble White
 Noble Gold Base Metal
 Noble Y Post and Core

CUSTOM TEMPORARY

Temporary Crown Tooth #: _____
 Temporary Bridge Shade: _____
 Metal Reinforcement
 E-Dent Bridge

IF NOT ENOUGH OCCLUSAL CLEARANCE

Metal Occlusion Metal Island
 Reduce Opposing Reduce Prep
 Reduction Coping

Would you like this to be added to your Doctor Preferences?

Yes No

Payment is due upon receipt of statement. Payment not received by the end of the following month is subject to a 1.5% per month service charge on the unpaid balance plus all collection costs if incurred. Your signature is acceptance of these terms.

Each prescription must be completed and signed.

X _____
Doctor Signature License Number

GOAL OF FINAL CASE

Close Diastemas Restore Worn Teeth
 Change Shape Normal Guidance
 Move Midline Widen Smile
 Restore to CR Feminize Smile
 Straighten Teeth Rejuvenate Smile
 Lengthen Teeth Restore Morphology
 Level Occlusal Plane Replace Missing Teeth

Other: _____

Teeth to be restored: _____

Teeth to be replaced: _____

TOOTH SHAPE

Maintain Existing
 Match Photos
 Follow Intraoral Mock-Up
 Make Ideal

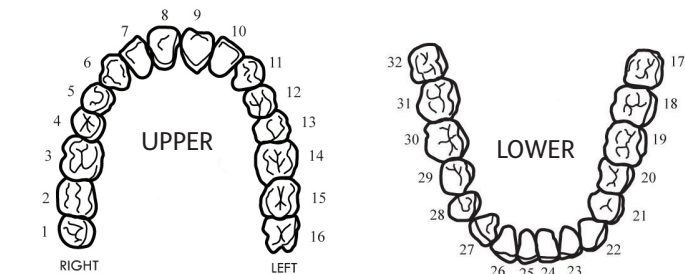


#6 ___ #7 ___ #8 ___ #9 ___ #10 ___ #11 ___

Overjet: _____ mm Overbite: _____ mm

ALL RX FORMS

Follow the QR code to print more RX forms!



Print 2 copies of completed script, keep one for your records and send the other one with the case. 10/21