

Dr. _____ Date: _____

Address: _____

City: _____ State: _____

Phone: _____ Zip: _____

Patient: _____ Age: _____

Male Female

Specialist/Referral: _____

Return Request Date: _____ Time: _____

ENCLOSED WITH CASE

<input type="checkbox"/> Impression	<input type="checkbox"/> Master Model	<input type="checkbox"/> Old Crown
<input type="checkbox"/> Study Model	<input type="checkbox"/> Diag. Wax-up	<input type="checkbox"/> Photos
<input type="checkbox"/> Denture	<input type="checkbox"/> Attachment	<input type="checkbox"/> Bite Relation
<input type="checkbox"/> Facebow	<input type="checkbox"/> Opposing Model	<input type="checkbox"/> Articulator

<input type="checkbox"/> Copings	Amount Included _____	Has this case been disinfected? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Analogs	_____	
<input type="checkbox"/> Abutments	_____	
<input type="checkbox"/> Screws	_____	

Other: _____

Please send a copy of the surgical note

Digital Scan:

Date Sent: _____ Time Sent: _____

System: _____

Special Instructions:

Please call Please Text: # _____



2065 W Woodland • Springfield, MO • 65807
• 800.462.3569 •

Abutment Selection

- PT.-Specific Milled:**
 - Titanium Gold Hue Zirconia
- Stock**
- UCLA:**
 - High Noble White High Noble Gold
- Zimmer/ Biomet Encode**
- Temporary**
- Screw Retained**
- Cementable**
- Removable**
- Screwmentable:**
 - Place screw accesshole, but do not cement
 - Place screw accesshole, and cement (extra charge for cement)

Abutment Emergence Profile

- Anatomical Tissue Displacement
- Blanching Ok Moderate Tissue Displacement (default)
- No Blanching Minimal Tissue Displacement

Abutment Margin Design

- Shoulder (default) Chamfer Feather

Surgical Guide

TOTAL IMPLANT PACKAGE

Simplete Abutment Process?* Yes No
(Includes patient-specific abutment, abutment screw, placement jig, lab analog, soft tissue model)

*Call for details

IMPLANTS

If no occlusal clearance: Call Adjust Opposing

(Please Include Impression Components with Case)

Brand	Type	Size	Tooth#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Locators All on 4*
(Minimum Vertical: 12 mm Fixed, 14 mm Removable)

Restoration Selection

- E-Zr Layered E-Zr Total
- Porcelain to High Noble Yellow IPS e.Max
- Porcelain to High Noble White Full Cast
- Porcelain to Noble White Porcelain to Base Metal

Upgrade My Restoration to *Capella*

Shade: Final Shade: _____
Pink Porcelain at gingiva? Yes No

Occlusal Staining

- None Light Medium Heavy

Embrasures

- Open Closed

Contacts

- Broad & Tight Pinpoint Light

Surface Anatomy

- Smooth Moderate Textured

ALL RX FORMS

www.EdmondsDentalProsthetics.com/resources

Follow the QR Code to print more Rx forms



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

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