

Rx DATE DELIVER BY 5:00PM ON

DOCTOR'S NAME (PLEASE PRINT)

DOCTOR'S ADDRESS PHONE

M / F
 PATIENT'S NAME (Last Name, First Name) Sex AGE

TEETH NUMBERS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

PHOTOS INCLUDED: UPLOADED ONLINE NO

IF INSUFFICIENT ROOM:

Please Call Reduction Coping Reduce & Mark

FABRICATION PURPOSE: Correct Malalignment Close Spaces
 Increase Length Color Change

SURFACE TEXTURE: Smooth Moderate Heavy

FIXED: METAL - FREE

e.max e.max Ultra Capital Zi Esthetic™ (layered zirconia)
 Complete Z™ (full-contour zirconia) Complete Z Ultra™ (premium option)

FIXED: METAL

PFM ALLOY: (Circle Alloy Color) **FULL CAST ALLOY:** (Circle Alloy Color)

High Noble Yellow/White (precious) High Noble Yellow/White (precious)
 Noble (semi-precious) Noble Yellow/White (semi-precious)

METAL DESIGN:

BAND AT BUCCAL: Hair Line 1 mm 2 mm No metal exposed
 BAND AT LINGUAL: Hair Line 1 mm 2 mm No metal exposed

PONTIC DESIGN:

Saddle Ridge Lap
 Conical
 Modified Ridge Lap
 Ovate

TRY-IN: Framework Bisque

BUTT JOINTS: 180° 360°

CASE INSTRUCTIONS

Known Patient Allergies:

Attention: _____
 Call Me Please evaluate my work
 Please Send: Rx's Shipping labels Boxes

SHADING CHART

Shade of Prepared Teeth: **Shade Desired:** Anterior Expert Shade System® Photos Sent

Value:
 High (bright)
 Medium
 Low

Occlusal Stain:
 None
 Light
 Medium
 Heavy

REMOVABLES

CAST PARTIALS:

FREE Survey/Design Casting Try-In Acetal Clasp
 Biteblock Set-Up/Try-In Flex Clasp (clear or pink)

DENTURE:

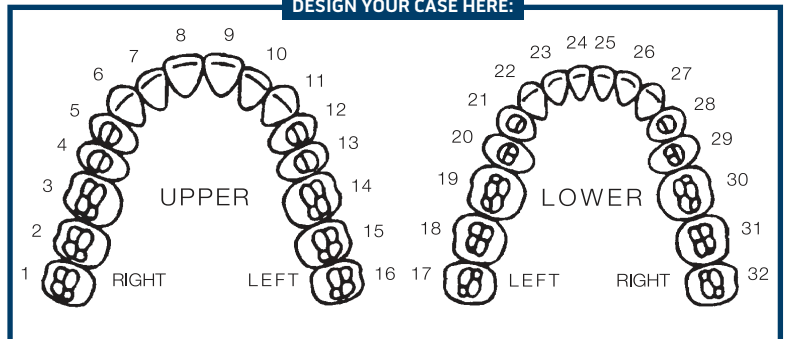
Custom Tray Try-In Reline Bioform IPN
 Biteblock Finish Rebase BlueLine
 Set-Up Repair Soft Liner Portrait
 Economy Porcelain

Shade: Ant. _____ Post. _____
 Mould: Ant. _____ Post. _____

ACRYLIC: Regular Flexible Partial SR-Ivocap
FINISH: Smooth Characterized

NIGHTGUARDS: Intelliform™ SafeGuard™ Hard Multi-color (strap included)
 Hard Nightguard SafeGuard™ Hard/Soft Clear Vinyl
 Hard/Soft Nightguard

DESIGN YOUR CASE HERE:



FOR LAB USE ONLY:

I authorize the above procedure to be performed.

SIGNATURE OF DENTIST

License #

"By signing above, I have acknowledged my understanding that BonaDent's services are fee-based services, and agree to pay for these services. I agree to pay interest charges on any unpaid balance that has not been paid within 30 days of the billing date in the amount of 2% per month for any work performed pursuant to this prescription and I further agree to pay all of BonaDent's reasonable fees and collection costs in the event any amount due for work performed hereunder is referred for collection."