

Rx DATE _____ DELIVER BY 5:00PM ON _____

DOCTOR'S NAME (PLEASE PRINT) _____

DOCTOR'S ADDRESS _____

E-MAIL ADDRESS _____ PHONE _____

PATIENT'S NAME (Last Name, First Name) _____ Sex M / F 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 **PORCELAIN MARGIN:** 180° 360°

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

Hypo-Calcification Posterior Occlusal Characterization

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 Esthetic: BlueLine DCL
 Biteblock Finish Rebase Premium: Delara
 Set-Up Repair Soft Liner Economy

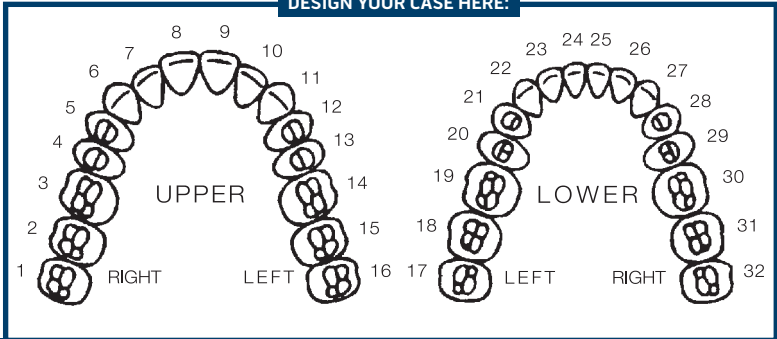
Shade: Ant. _____ Post. _____
 Mould: Ant. _____ Post. _____

ACRYLIC: Regular Flexible Partial SR-Ivocap
FINISH: Injected Heat Processed Poured

CHARACTERIZATION: Smooth Characterized

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

DESIGN YOUR CASE HERE:



CASE INSTRUCTIONS

FOR LAB USE ONLY:

Known Patient Allergies: _____

Attention: _____
 Call Me _____ Please evaluate my work _____
 Please Send: Rxs Shipping labels Boxes

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."

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