

RX - Remember to include: Rx form, Impression, Opposite Model and Wax bite

Dental Work Order Form

Return Date: _____

Crown and Bridge Removable Denture

<input type="checkbox"/> Frame <input type="checkbox"/> Try in <input type="checkbox"/> Finish	<input type="checkbox"/> Try in <input type="checkbox"/> Finish
<input type="checkbox"/> PFM Cr./Br	<input type="checkbox"/> Co-Cr Framework
<input type="checkbox"/> Cercon	<input type="checkbox"/> Vitallium Framework
<input type="checkbox"/> E-max//Empress II	<input type="checkbox"/> Titanium Framework
<input type="checkbox"/> F.G.C (40% Gold / 60% Gold)	<input type="checkbox"/> Acrylic/Imd Denture
<input type="checkbox"/> Implant	<input type="checkbox"/> Valplast
<input type="checkbox"/> Full Metal Crown (<input type="checkbox"/> NP or <input type="checkbox"/> SP)	<input type="checkbox"/> Wax Bite
<input type="checkbox"/> Metal Inlay/Onlay	<input type="checkbox"/> Special Tray
<input type="checkbox"/> Post & Core	<input type="checkbox"/> Night Guard
<input type="checkbox"/> PFM + Post (1 piece)	<input type="checkbox"/> Temporary
<input type="checkbox"/> Composit Inlay/ Onlay	<input type="checkbox"/> Attachment
<input type="checkbox"/> Captek	
<input type="checkbox"/> Express Veneer	
<input type="checkbox"/> Express Inlay	
<input type="checkbox"/> Express Onlay	
<input type="checkbox"/> Telescope	

Patient Information

Name: _____
 Sex: _____
 Age: _____
 Code: _____

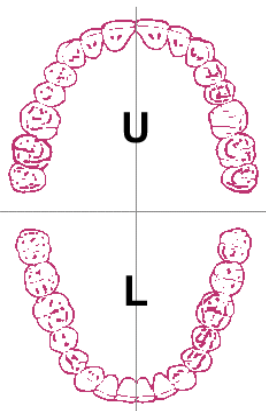
Dentist _____
 Company _____
 Address _____

 Phone: _____
 Email: _____
 Date: _____
 Date Needed: _____

Additional Instructions:

Design Instructions

Material	Material Design
<input type="checkbox"/> Co-Cr	<input type="checkbox"/> No Metal Margin
<input type="checkbox"/> Non-Precious	<input type="checkbox"/> Porcelain Shoulder
<input type="checkbox"/> Semi-Precious	<input type="checkbox"/> Lingual Metal Margin
<input type="checkbox"/> High Noble White	<input type="checkbox"/> All Metal Margin
<input type="checkbox"/> High Noble Yellow	<input type="checkbox"/> 3/4 Occlusal Metal
	<input type="checkbox"/> Occlusal Metal



Tray/Impression:

Bite/Articulator:

Model/Other:





OCCL. STAIN:



None Medium
 Light Dark

Shade: _____




Embrasure

Open 
 Close 

Extent Proximal Contact

Extended 
 Normal 

Occlusal contact

Heavy 
 Light 
 Open 

Pontic design

Full Ridge Partial Ridge No Ridge Sanitary Bullet

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