

DR NAME _____ **PT NAME** FIRST _____ AGE _____
 ADDRESS _____ LAST _____ FEMALE MALE
 CITY _____ STATE _____ ZIP _____ PHONE _____ **DUE DATE** FINISH _____ TRY IN _____ **CALL ME**
ENCLOSED WITH CASE: Model Metal Trays Teeth Shade Tab Articulator Bite Impressions Photo (Preferred) Other _____

IMPLANT SYSTEM USED

SIZE

CAD/CAM ABUTMENT

Titanium (Ti) Zirconia (Zr)
 Other _____

SCREW RETAINED OR **CEMENT RETAINED**

CEMENT RETAINED In Lab Chairside

OTHER ABUTMENT OPTIONS

Custom Cast Metal Stock

MARGIN DESIGN B/F M D L

Subgingival _____

Supragingival _____

Flush with Tissue _____
 (In mm)

ABUTMENT CLEARANCE FROM OPPOSING

In mm _____

BLANCHING

Yes No
 Or planning incision and suturing

ANODIZE

REFERENCE #

FINAL RESTORATION TYPE

DSez™ (Esthetic Monolithic Zirconia)
 DSmz™ (Monolithic Zirconia)
 DSz™ (Layered Zirconia)
 IPS e.max®
 PFM Specify alloy _____
 Full Cast
 OTHER _____

SHADE

DESIRED _____

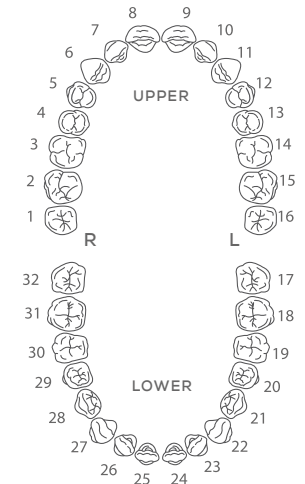


OCCUSAL STAINING

NONE
 LIGHT
 MEDIUM
 DARK



PLEASE INDICATE TOOTH NUMBER TO BE RESTORED:



INSTRUCTIONS

SPLINTS

U L Hard U L Brux-eze™
 Comfort H/S™ Rem-e-deze™
 Sports Guard DSG Relaxer™
 OTHER _____

DR SIGNATURE _____

DR LICENSE # _____

For Warranty Information: Please review the DSG Warranty Policy at www.dentalservices.net/dsg-warranty

DO YOU NEED? Shipping Boxes **RXS:** Standard Fixed Removable Local (WHERE AVAILABLE)
 Shipping Labels Implant Cosmetic Ortho/Sleep Value

TERMS: Net 15th of month. A finance charge of 1½% per month (18% annual) will be added to past due invoices F IMPI 00