

**DR NAME** \_\_\_\_\_ **PT NAME** FIRST \_\_\_\_\_ AGE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ LAST \_\_\_\_\_ FEMALE  MALE   
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_ **DUE DATE** FINISH \_\_\_\_\_ TRY IN \_\_\_\_\_  
**DSO PRACTICE NAME** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_ **CALL ME**   
 (IF APPLICABLE)

**ENCLOSED WITH CASE:**  Model  Shade Tab  Bite  Impressions  Photo (Preferred)  Articulator  Metal Trays  Teeth  Other \_\_\_\_\_

**NON-METAL RESTORATION**

- DSez™ (Esthetic Monolithic Zirconia)
- DSzmz™ (Monolithic Zirconia)
- DSz™ (Layered Zirconia)
- IPS e.max®
- BruxZir®

OTHER \_\_\_\_\_

**PORCELAIN FUSED TO METAL**

- PFM NP/Base  PFM White High Noble
- PFM Noble  PFM Yellow High Noble
- Semi Precious

OTHER \_\_\_\_\_

**FULL CAST RESTORATION**

- NP/Base  White High Noble
- Noble White  Yellow High Noble
- Noble Yellow

**REMOVABLE**

- |                                          |                                      |                                    |                                   |
|------------------------------------------|--------------------------------------|------------------------------------|-----------------------------------|
| <b>U L</b>                               | <input type="checkbox"/> Economy     | <b>U L</b>                         | <input type="checkbox"/> Bite Rim |
| <input type="checkbox"/> Standard        | <input type="checkbox"/> Custom Tray | <input type="checkbox"/> Emergency | (Spare Denture)                   |
| <input type="checkbox"/> Premium         | <input type="checkbox"/> Flexible    | <b>Shade</b>                       | _____                             |
| <input type="checkbox"/> Acrylic Partial | <input type="checkbox"/> Flipper     | <b>Mould</b>                       | _____                             |
|                                          |                                      | <b>Brand</b>                       | _____                             |
|                                          |                                      | <b>Acrylic Shade</b>               | _____                             |

**PARTIAL**

- |                                                             |                                         |                                               |                                           |
|-------------------------------------------------------------|-----------------------------------------|-----------------------------------------------|-------------------------------------------|
| <b>U L</b>                                                  | <input type="checkbox"/> Standard CRCO  | <b>U L</b>                                    | <input type="checkbox"/> w/ Occlusion Rim |
| <input type="checkbox"/> Premium CRCO                       | <input type="checkbox"/> Semi Precision | <input type="checkbox"/> VisiClear™           |                                           |
| <input type="checkbox"/> Flexible                           |                                         | <input type="checkbox"/> Clear Cosmetic Clasp |                                           |
| <input type="checkbox"/> New Partial to fit Crown or Bridge |                                         | <b>Name/Identifier</b>                        | _____                                     |
|                                                             |                                         | <b>in Appliance</b>                           | _____                                     |

**IMPLANT**

Implant System Used \_\_\_\_\_

**SIZE** \_\_\_\_\_

**CAD/CAM ABUTMENT**

- Titanium (Ti)  Zirconia (Zr)
- Other \_\_\_\_\_

**SCREW RETAINED** OR  **CEMENT RETAINED**

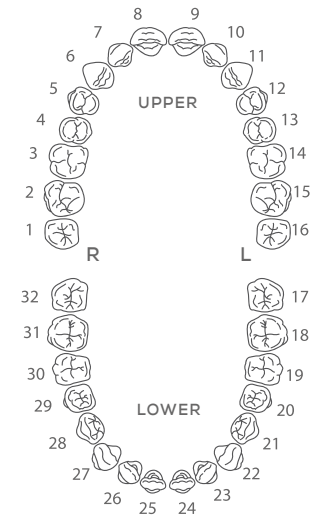
**CEMENT RETAINED**  In Lab  Chairside

**ANODIZE**

**SPLINTS**

- |                                       |                                       |                                      |                                       |
|---------------------------------------|---------------------------------------|--------------------------------------|---------------------------------------|
| <b>U L</b>                            | <input type="checkbox"/> Hard         | <b>U L</b>                           | <input type="checkbox"/> Brux-eze™    |
| <input type="checkbox"/> Comfort H/S™ | <input type="checkbox"/> Sports Guard | <input type="checkbox"/> Rem-e-deze™ | <input type="checkbox"/> DSG Relaxer™ |
| <input type="checkbox"/> OTHER        | _____                                 |                                      |                                       |

PLEASE INDICATE TOOTH NUMBER TO BE RESTORED:



**INSTRUCTIONS**

**SHADE**

DESIRED \_\_\_\_\_

STUMP \_\_\_\_\_



**OCCUSAL**

- NONE  Medium

**STAINING**

- Light  Dark



**DR SIGNATURE** \_\_\_\_\_

DR LICENSE # \_\_\_\_\_

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

**DO YOU NEED?**

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

**TERMS:** Net 15th of month. A finance charge of 1 1/2% per month (18% annual) will be added to past due invoices F STA1 02