Dental Services Group

STANDARD PRESCRIPTION FORM

LABORATORY PROCEDURE AUTHORIZATION | DR SIGNATURE REQUIRED

SEE REVERSE SIDE FOR LAB LOCATIONS
www.dentalservices.net

DR NAME _____ **TODAY'S DATE** _____ **CALL ME** ☐

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

PT NAME FIRST _____ AGE _____

LAST _____ FEMALE ☐ MALE ☐

DSO PRACTICE NAME (IF APPLICABLE) _____ **DUE DATE** FINISH _____ TRY IN _____

ENCLOSED WITH CASE: ☐ Model ☐ Shade Tab ☐ Bite ☐ Impressions ☐ Photo (Preferred) ☐ Articulator ☐ Metal Trays ☐ Teeth ☐ Other _____

NON-METAL RESTORATION

- ☐ IPS e.max® ZirCAD Prime
- ☐ DSmz™ (Monolithic Zirconia)
- ☐ DSez™ (Esthetic Monolithic Zirconia)
- ☐ DSz™ (Layered Zirconia)
- ☐ IPS e.max® (Lithium Disilicate)

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

U	L		U	L	
☐	☐	Economy	☐	☐	Flipper
☐	☐	Standard	☐	☐	Bite Rim
☐	☐	Premium	☐	☐	Custom Tray
☐	☐	Flexible	☐	☐	Emergency (Spare Denture)
☐	☐	Acrylic Partial			

Shade _____
Mould _____
Brand _____
Acrylic Shade _____

DIGITAL DENTURE

- ☐☐ ProFX® Premium
- ☐☐ ProFX® Standard

PARTIAL

U	L		U	L	
☐	☐	Standard CRCO	☐	☐	w/ Occlusion Rim
☐	☐	Premium CRCO	☐	☐	Semi Precision
☐	☐	VisiClear™			
☐	☐	Flexible			
☐	☐	Clear Cosmetic Clasp			
☐	☐	New Partial to fit Crown or Bridge			

Name/Identifier in Appliance _____

IMPLANT

Implant System Used _____

SIZE _____

☐ **CUSTOM ABUTMENT**
- ☐ CAD/CAM Titanium ☐ CAD/CAM Zirconia
- ☐ OEM UCLA Cast: Labor Metal Extra

*This restoration must be cemented chariside

☐ **SCREW RETAINED**

☐ **Recieve restoration all in one piece**
- ☐ CAD/CAM Titanium Cement in Lab ☐ CAD/CAM Zirconia Cement in Lab
- ☐ OEM UCLA Cast: Labor Metal Extra

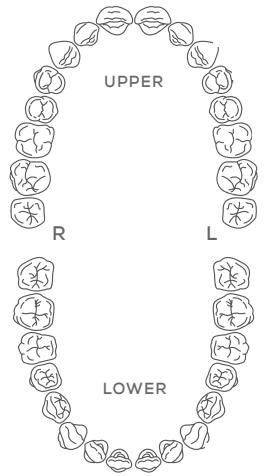
☐ **Recieve restoration in two pieces** w/ access holes
*This restoration must be cemented chariside

☐ Anodize/Gold Hue

SPLINTS

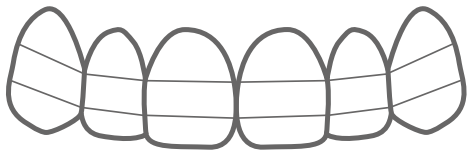
U	L		U	L	
☐	☐	Hard	☐	☐	Brux-eze™
☐	☐	Comfort H/S™	☐	☐	Rem-e-deze™
☐	☐	Sports Guard	☐	☐	DSG Relaxer™
☐	☐	OTHER _____			

PLEASE INDICATE TOOTH NUMBER TO BE RESTORED:

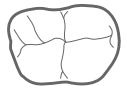


INSTRUCTIONS

SHADE DESIRED _____ STUMP _____



OCCLUSAL STAINING ☐ NONE ☐ Light ☐ Medium ☐ 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 1½% per month (18% annual) will be added to past due invoices F STA1 03