STUDIO 32
DENTAL LABORATORY

Office Use Only

HIAWATHA & ANKENY 319-298-9800 | MASON CITY 641-380-0362

DOCTOR:_____ PHONE:_____

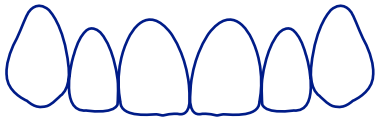
PATIENT:_____

DATE SENT:_____ WANTED:_____

☐ PLEASE CALL DOCTOR BEFORE STARTING THIS CASE

SHADE INSTRUCTIONS

SHADE #: _____



OCCLUSAL STAINING	☐ NONE	☐ LIGHT	☐ MEDIUM	☐ HEAVY
SURFACE TEXTURE	☐ SMOOTH	☐ MODERATE	☐ HEAVY	
LUSTER	☐ SHINY	☐ MODERATE	☐ DULL	

PORCELAIN VENEERS *Please provide the following information:*

PURPOSE OF VENEER

☐ CHANGE COLOR ☐ CORRECT MALALIGNMENT

☐ CLOSE SPACE ☐ INCREASE LENGTH_____MM

☐ SHADE OF PREPARED TEETH_____

SPECIFIC INSTRUCTIONS

℞

TOOTH NUMBER

ENCLOSED WITH CASE

☐ Imp
☐ Bite
☐ Models
☐ Photos
☐ Other:

FIXED Rx

PRODUCT SELECTION

ZIRCONIA

☐ ZR32 ZIRCONIA (FULL CONTOUR ZIRCONIA)

☐ ZR32 ZIRCONIA (LAYERED)

☐ ZR HT ZIRCONIA (FULL CONTOUR HIGH TRANSLUCENT ZIRCONIA)

ALL-CERAMIC

☐ LITHIUM DISILICATE

PFM ALLOYS

☐ NON-PRECIOUS

☐ NOBLE (SEMI-PRECIOUS)

☐ HIGH NOBLE

FULL CAST ALLOYS

☐ SEMI-PRECIOUS (WHITE)

☐ 52% GOLD

☐ 62% GOLD

☐ ECONOMY NOBLE METAL

CERAMAGE ZIRCONIA SILICA

☐ INLAY, ONLAY

☐ PINK GUM

IMPLANTS

☐ TITANIUM BASE (STOCK)

☐ ATLANTIS® CUSTOM ABUTMENT

☐ STRAUMANN CUSTOM ABUTMENT

☐ PARTS SUPPLIED by DOCTOR

IMPLANT SYSTEM: _____

MANUFACTURER: _____

☐ CUSTOM ☐ STOCK

SIZES: _____

Specify implant brand, system and diameter on Rx

CASE SPECIFICATIONS

BUCCAL MARGIN DESIGN

☐ HAIRLINE OR _____ MM ON BUCCAL

☐ METAL JUNCTION MARGIN*

☐ PORCELAIN BUTT MARGIN (90° SHOULDER REG.)

** Standard unless specified otherwise*

METAL DESIGN

☐ COPING WITH FULL PORCELAIN COVERAGE

☐ METAL COPING WITH PORCELAIN COVERAGE*

☐ METAL OCCLUSAL EXCLUDING BUCCAL CUSP

☐ METAL OCCLUSAL INCLUDING BUCCAL CUSP

**Standard unless specified otherwise*

PONTIC DESIGN

☐ ☐ ☐* ☐ ☐

**Standard unless specified otherwise*

STAGES

☐ MTI/COPING

☐ BISQUE BAKE

☐ GLAZED POLISH

IF NO OCCLUSAL CLEARANCE

☐ METAL OCCLUSAL

☐ REDUCTION COPING

☐ SPOT OPPOSING

Would you like this to be a permanent note in your master file* ☐ ***YES* ☐ ***NO***

NOTE: PLEASE SEND A STUDY MODEL ON ALL WORK INVOLVING ANTERIOR TEETH
(Cost of Collection of any Account will be paid by the Customer)

Signature : _____ *D.D.S. License #*_____

☐ **Please send more Rx Forms** ☐ **Send more boxes** ☐ **Other**