

### CASE INFORMATION

|                       |                      |                              |                      |
|-----------------------|----------------------|------------------------------|----------------------|
| Doctor / Prescriber * | Practice *           | Case ID / Patient Initials * | RX Date *            |
| <input type="text"/>  | <input type="text"/> | <input type="text"/>         | <input type="text"/> |
| Office Phone          | Office Email         | Requested Due Date           | Shade                |
| <input type="text"/>  | <input type="text"/> | <input type="text"/>         | <input type="text"/> |
| Office Address        | Tooth / Unit #       |                              | Arch / Site          |
| <input type="text"/>  | <input type="text"/> |                              | <input type="text"/> |

#### RECORDS INCLUDED

☐ Digital scan
 ☐ Impression
 ☐ Model
 ☐ Bite
 ☐ Photos
 ☐ Other

### SERVICE TYPE

☐ Orthodontic / Appliance
 ☐ Crown & Bridge  
☐ Partial / Denture
 ☐ Implant

#### ORTHO

☐ RPE / Hyrax / Haas  
☐ Essix / Clear Retainer  
☐ Hawley  
☐ TPA / Lingual Arch

#### DENTURE / PARTIAL

☐ Full Denture  
☐ Partial Denture  
☐ Flipper  
☐ Repair / Reline

#### CROWN / IMPLANT

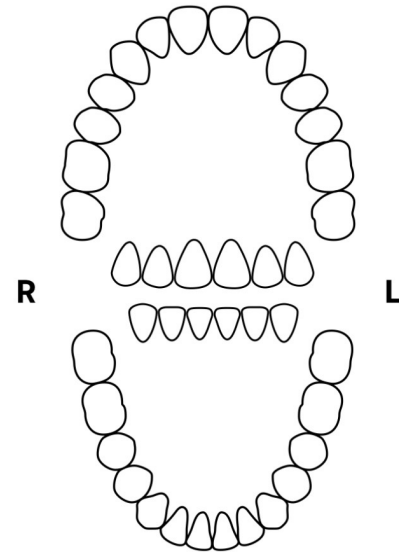
☐ Zirconia / e.max  
☐ Crown / Bridge  
☐ Implant / Screw-retained

### TOOTH DIAGRAM

Mark teeth, bands, design c

#### Material / Design Notes

#### Occl / Contact / Shade



### LAB INSTRUCTIONS

|                           |                      |                             |                      |
|---------------------------|----------------------|-----------------------------|----------------------|
| Printed Prescriber Name * | RCDSO #              | Signature / Authorization * | Date *               |
| <input type="text"/>      | <input type="text"/> | <input type="text"/>        | <input type="text"/> |