

RESTORATIVE Rx

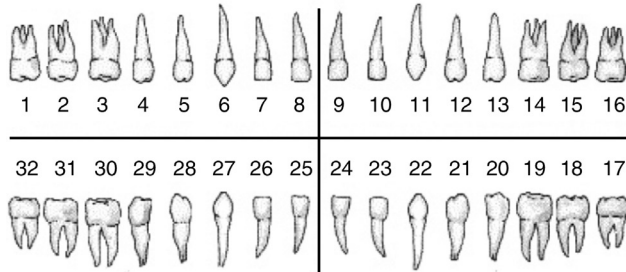
Rx Date: _____ Due Date: _____ Appt. Date: _____ **NOTE: Do not appoint until ≥ 2 days post due date.**

Prescribing Doctor: _____ Contact: _____ Phone: _____

Patient Name: _____ Age: _____ Gender: _____

Teeth

- Circle single units
- Bracket splinted/bridges



Shade: _____ Photo Sent: Yes No
 Photo recommended for anterior restorations. Please send to: support@techsourcedental.com.

Adjacent Teeth: Translucent Opaque High Value Low Value

FIXED RESTORATIONS

- TFZ Value
- TFZ Ideal
- TZ³ Ultra
- Porcelain Fused to Zirconia
- eMax / Lithium Disilicate
- Provisional

SPECIAL INSTRUCTIONS:

ABUTMENTS

IMPLANT MANUFACTURER

Brand: _____ Size: _____
 Brand: _____ Size: _____

If multiple units, please specify each.

ABUTMENT MANUFACTURER

- Atlantis
- BioHorizons
- Biomet Zimmer
- Nobel Biocare
- Straumann
- Other: _____

ABUTMENT MATERIAL

- Custom Titanium
- Custom Gold-shaded Titanium
- Custom Zirconia with Ti-Base
- Titanium Base with Full-Contour Zr Crown (e.g. Straumann Variobase, Nobel Universal base)
- Cement-retained
- Screw-retained
- _____ One Piece (cemented in lab)
- _____ Two Piece (cemented by doctor)

DOCTOR SIGNATURE: _____

LICENSE NUMBER: _____

ALL COMPONENTS MUST BE SENT WITH CASE.

CLOSED TRAY: Implant replica & implant transfer | OPEN TRAY: Guide pin, implant pickup, & implant replica

INCOMPLETE LAB SLIPS MAY RESULT IN DELAYED RETURN.