SYNERGY CERAMICS
DENTAL STUDIO

DOCTOR NAME: _____ DATE: _____ *RETURN DATE: _____

PATIENT NAME: _____ PATIENT AGE: _____ ○ MALE ○ FEMALE

*Please allow four weeks from the preparation date for restorations and two weeks for diagnostic wax-ups.

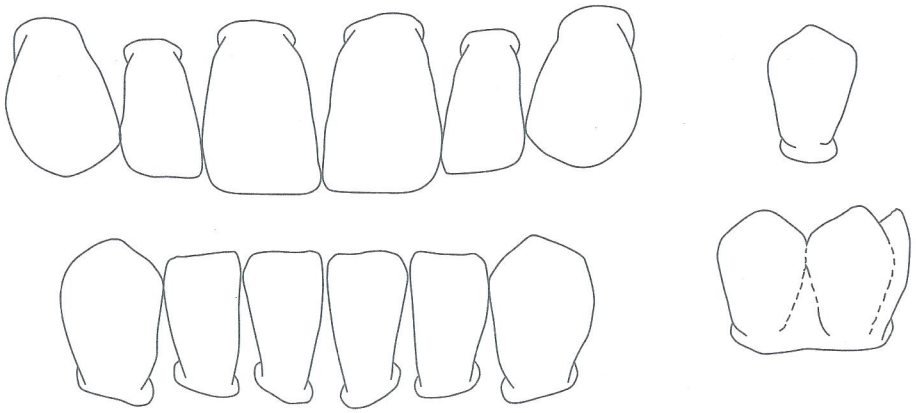
TYPE OF RESTORATION
- ○ Porcelain Veneer
- ○ All Porcelain Bonded Crown
- ○ Porcelain Inlay/Onlay
- ○ Zirconia Crown
- ○ Zirconia Bridge
- ○ Monolithic Zirconia Crown
- ○ e.max® Crown
- ○ e.max® Veneer
- ○ Atlantis™ Custom Abutment
- ○ Diagnostic Wax-up
- ○ Provisional

ENCLOSED WITH CASE
- ○ Face Bow
- ○ Study Model (required for multiple unit anterior cases)
- ○ Bites (C.R. or C.O.)
- ○ Impression
- ○ Opposing Model
- ○ Slides, Photo, or other shade info
- ○ Other: _____
- ○ Implant Components
  Type: _____

ARE YOU RESTORING THE OPPOSING?
○ Yes ○ No

PURPOSE OF VENEER FABRICATION
- ○ Change Shade
- ○ Close Diastemas
- ○ Correction of Alignment
- ○ Increase Length _____ mm
- ○ Tetracycline

SURFACE ANATOMY OF ANTERIOR TEETH
- ○ Smooth
- ○ Moderate
- ○ Heavy



Please indicate teeth to be restored.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

SHADE OF RESTORATION: _____

SHADE OF PREPARED TEETH (REQUIRED): _____

OCCLUSAL STAINING:
○ Light ○ Medium ○ Heavy ○ None

SPECIAL INSTRUCTIONS:

DOCTOR'S SIGNATURE: _____

LICENSE #: _____

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