



DR: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_ SEX: M  F  AGE: \_\_\_\_\_

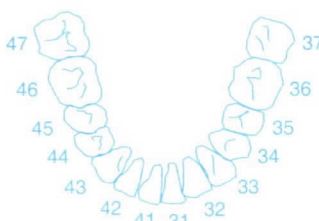
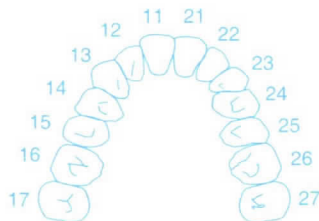
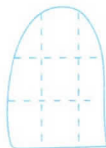
DATE REQUIRED: \_\_\_\_\_ AM  PM







Rx

Shade Specification:

PLEASE INDICATE CASE REQUIREMENTS BELOW

- A. Metal  Precious  Semi-prec.  Non-prec.
- B. Occlusion  Metal  Porcelain
- C. Centric contact  Foil relief  Positive contact  Cusp fossa
- D. Lateral excursion  Cuspid guidance  Group function
- E. Margin adaptation  Exactly to finish line  Slight overextension
- F. Labial margin  Fine metal collar  Porcelain butt margin  Porcelain to margin



- G. Pontic design        
- H. Contacts (embrassures)  1. Broad    2. Normal    3. Point 