ROMADENT CERAMICS DENTAL LABORATORY

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www.romadentceramics.com

Doctor: _____ **Date:** _____

Patient: _____ **Sex:** M F **Age:** _____

Finishing Date: _____ **Time Required:** _____ AM PM

❑ **PLEASE RETURN FOR TRIMMING**

❑ **PLEASE CALL ME (Before proceeding with the case)**

PLEASE INDICATE TYPE OF RESTORATION

ALL CERAMIC: ❑ Ips Empress ❑ Ips Emax ❑ Zirconia (CAD-CAM) ❑ LAVA

FULL METAL RESTORATION: ❑ Full Gold Crown ❑ 3/4 Crown ❑ Inlay/Overlay

COMPOSITE: ❑ Cristobal ❑ Other _____ **IMPLANTS:** ❑ Noble Biocare ❑ Strauman

PFM: ❑ Ips D-Sign ❑ Duceragold ❑ DIAGNOSTIC WAX UP ❑ TEMPORARY CROWNS

METAL SELECTION: ❑ Yellow Gold ❑ White Gold ❑ H.Noble ❑ Noble ❑ Non Precious

FORM OF CROWN DESIRED: ❑ Follow Study Model ❑ Match Existing ❑ Make Ideal

OCCULSAL CLEARANCE: ❑ Centric Contact ❑ Cusp to Fossa ❑ Foil Relief

OCCULSAL SURFACE: ❑ Metal ❑ Porcelain

INTERPROXIMAL CONTACTS: ❑ Broad ❑ Normal ❑ Point

LATERAL EXCURSION: ❑ Cuspid Guidance ❑ Group Function

LABIAL MARGIN: ❑ Fine Metal Collar ❑ Porcelain to Margin ❑ Porcelian Butt Margin

OCCULSAL STAINING: ❑ Light ❑ Dark ❑ None

PONTIC DESIGN

SHADE _____

GING. SHADE _____

STUMPF SHADE _____
(EMPRESS – EMAX)

ADDITIONAL INSTRUCTION:

PLEASE SEND

❑ Fixed Rx's

❑ Removable Rx's

❑ Bags ❑ Boxes

DISINFECTED _____

Doctor's Signature _____