Cosmetic Rx

1. Type of Restoration

All-Porcelain

(Fill out boxes #1-10)	Margin required
❑ a. Feldspathic	Chamfer margin
❑ b. E Max Veneer	Chamfer margin
❑ c. E Max (Layered) (crown)	Shoulder margin
❑ d. E Max (Stained) (Crown, Inlay, Onlay)	Shoulder margin
❑ e. E max (Crown, Ant. Bridge)	Shoulder margin
❑ f. Procera Alumina	Chamfer margin
❑ g. Procera Zirconia	Chamfer margin
❑ h. Zirconia (Lava, Cercon, Dental Wings)	Chamfer margin

Composite

(Fill out boxes #1-10) (Crown, Bridge, Veneer, Inlay, Onlay)

❑ i. Fibre Kor	Shoulder margin
❑ j. Sinfony/Vectris	Shoulder margin
❑ k. Cristobal+	Shoulder margin

Other

❑ l. Temporaries (Fill out box #11)
❑ m. Diagnostic wax up (Fill out box #12)
❑ n. Putty or suck down matrix (Fill out box #12)

2. Reason for Restorations

❑ a. Tooth Needed Crown
❑ b. Change Length of Tooth
❑ c. Correct tooth Alignment
❑ d. Tooth Color
❑ e. Close Spaces

3. Occlusal stain

❑ a. None
❑ b. Light
❑ c. Heavy

4. Surface Texture

❑ a. Smooth Glaze
❑ b. Copy Natural Teeth

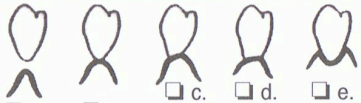
5. Occlusal Contact

❑ a. Out (0.5 mm)
❑ b. Light (0.3 mm)
❑ c. Contract (touch opp)

6. Gingival Embrasures

❑ a. Natural
❑ b. Open
❑ c. Closed
❑ Gum Tissue Model

7. Pontic Design



❑ a. ❑ b. ❑ c. ❑ d. ❑ e.

❑ No Ridge Relief

8. If Not Enough Occlusal Clearance

❑ a. Adjust opposing tooth ❑ b. Call

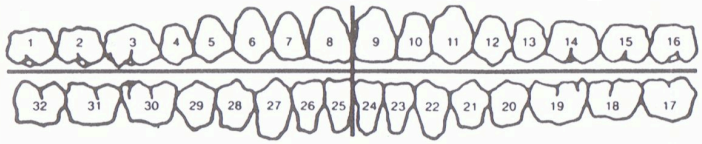
ZirámiX
the dental lab

795 FRANKLIN AVENUE FRANKLIN LAKES, NJ 07417
TEL: 888-825-2132 FAX: 201-891-5878
WWW.ZIRAMIX.COM

Doctor's Name

Address
City, State, Zip
Email Address _____
Patient Last Name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Patient First Name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Shipping Date |__|__|-|__|__|-|__|__| Male / Female
DATE DUE-Deliver case by 5PM on |__|__|-|__|__|-|__|__|

❑ **Finish** ❑ **Die Trim** ❑ **Bisque Try-In**



❑ Singles _____

❑ Bridge _____

(pontic #_____)

Dentist Signature _____ License # _____

Items Enclosed ___Imp. ___Model ___Bite ___Opposing
___Shade ___Pre-op Model ___Photo ___Model of Temps

9. Shade

Desired Shade_____
PLEASE SEND STUDY MODEL ON ALL CASES INVOLVING ANTERIOR TEETH

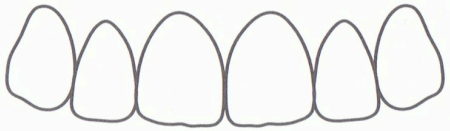
Stump / Prepped tooth shade* _____
***IMPORTANT: Please indicate the shade for any metal-free restorations**

Type of Shade Guide

❑ Vita 3D Guide ❑ Chromoscope ❑ Vita Classic
❑ Bioform ❑ Other _____

10. Tooth Mold of Desired

❑ a. Squared ❑ b. Ovoid ❑ c. Tapering



Tooth	Height	Width	Notes
#___	___mm	___mm	_____
#___	___mm	___mm	_____
#___	___mm	___mm	_____
#___	___mm	___mm	_____

11. Instructions for Temporaries

A. Reduction needed
❑ i. Light ❑ ii. Heavy
B. ❑ Splinted or ❑ Single Units
C. Wire reinforcement Yes No
D. Pontic Tooth Number_____

12. Diagnostic Wax Up

Prep Model: ❑ Yes ❑ No Dupl. Model: ❑ Yes ❑ No
Open Vertical: ❑ Yes ❑ No _____mm
Shift Midline: ❑ Yes ❑ No _____mm (Right of Left)

Shape and Contour
❑ a. Match Existing
❑ b. Make Ideal
❑ c. Smile Guide #_____

Incisal Embrasure
❑ a. Rounded
❑ b. Square
❑ c. Open

Reduction Stent: ❑ Incisal ❑ Labial
Temp Stent: ❑ Vacuum ❑ Putty/Wash
❑ Type of Future Restoration_____

-C & B / Removable restorations Available-

Please send more ❑ a. Shipping Labels ❑ d. Boxes ❑ b. Cosmetic Rx ❑ e. Removable Rx ❑ c. Crown & Bridge Rx ❑ f. Implanning

For Lab Use
Model _____ Trim _____ Wax _____
Porc. _____ Pol. _____ Q.C. _____

Revised 07/01/05