



Dental Design Studio, Inc

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Rx Date: _____

Please send: Bags / Rx's Disinfected? YES / NO
 Special Delivery Instructions:

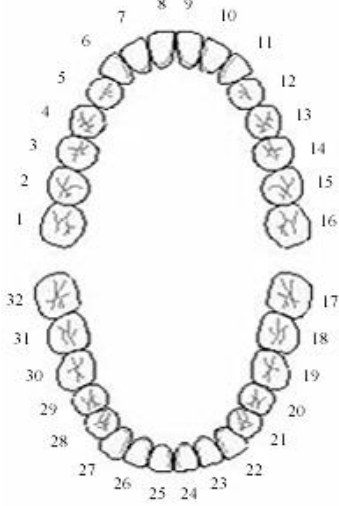
Send digital photos to Email: dds1lab@aol.com

Dr. _____ Phone _____

Patient: _____ M/F Age: _____ Try in / Finish _____ Due Date: _____ Am/Pm _____

DENTURES		SPLINTS		RELINE	REPAIR	ZIRCONIA/ALL CERAMICS		PORC. FUSED TO METAL	
<input type="checkbox"/> Ivocap	<input type="checkbox"/> Duplicate	<input type="checkbox"/> Hard / Soft	<input type="checkbox"/> Deprogrammer	<input type="checkbox"/> Hard	<input type="checkbox"/> Simple	<input type="checkbox"/> Katana - Zirconia	<input type="checkbox"/> Bruxir - Zirconia	<input type="checkbox"/> High Noble Yellow	<input type="checkbox"/> High Noble White
<input type="checkbox"/> Temporary	<input type="checkbox"/> Overdenture	<input type="checkbox"/> Clearsplint / Hard	<input type="checkbox"/> Invisible	<input type="checkbox"/> Soft	<input type="checkbox"/> Complex	<input type="checkbox"/> Zirconia - Layered	<input type="checkbox"/> e.Max® Press/CAD	<input type="checkbox"/> Noble White	<input type="checkbox"/> Noble Yellow
PARTIALS		STAYPLATE		CUSTOM TRAY		<input type="checkbox"/> e.Max Veneer	<input type="checkbox"/> e.Max Layered	<input type="checkbox"/> Semi Prec	<input type="checkbox"/> Titanium
<input type="checkbox"/> Chrome	<input type="checkbox"/> Duracetal™	<input type="checkbox"/> Acrylic	<input type="checkbox"/> W/W clasps	<input type="checkbox"/> Perforated		FULL METAL RESTORATION		MARGIN	
<input type="checkbox"/> Gold	<input type="checkbox"/> Duraflex™	<input type="checkbox"/> Immediate	<input type="checkbox"/> Ball clasps	<input type="checkbox"/> Non-Perforated		<input type="checkbox"/> High Noble Yellow	<input type="checkbox"/> Semi-Precious Yellow	<input type="checkbox"/> Standard	<input type="checkbox"/> Cust. Abutment
TEETH		HYBRID IMPLANTS		ESSEX		<input type="checkbox"/> High Noble White	<input type="checkbox"/> Semi-Precious White	<input type="checkbox"/> Porc. Margin	<input type="checkbox"/> Temporary implant crown
<input type="checkbox"/> Vitapan	<input type="checkbox"/> Ivoclar	<input type="checkbox"/> Hybrid - Overdenture	<input type="checkbox"/> Hybrid - Bar: Type: _____	<input type="checkbox"/> w/tooth	<input type="checkbox"/> retainer 1mm/2mm	<input type="checkbox"/> Titanium	<input type="checkbox"/> Inlay / Onlay	<input type="checkbox"/> Mtl buccal _____mm	
<input type="checkbox"/> Phonares	<input type="checkbox"/> Portrait	IMPLANT GUIDES		ORTHODONTIC		PONTIC DESIGN			
		<input type="checkbox"/> Drill Guide	<input type="checkbox"/> Bone Stent	<input type="checkbox"/> Hawley	<input type="checkbox"/> Band & Loop	<input type="checkbox"/> Sanitary <input type="checkbox"/> Bullet	<input type="checkbox"/> Metal Occlusion	<input type="checkbox"/> Maryland Bridge	
		<input type="checkbox"/> Clear Denture	<input type="checkbox"/> Clear w/trough			<input type="checkbox"/> Full ridge <input type="checkbox"/> Modified	<input type="checkbox"/> Spot Opposing	<input type="checkbox"/> CAD Temporary crown	
SHADE:		MOULD:					<input type="checkbox"/> Reduction Coping	<input type="checkbox"/> Diagnostic wax up	

- A1
- A2
- A3
- A3.5
- A4
- B1
- B2
- B3
- B4
- C1
- C2
- C3
- C4
- D1
- D2
- D3
- D4

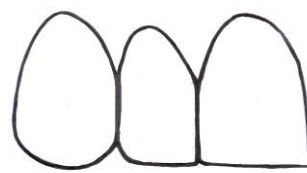


Please call doctor before starting

INCOMING CHECK LIST

- Alginate imp
- PVS imp
- Opposing
- Bite
- Old Partial
- Old Denture
- Study Models
- Old Models
- Articulator
- Face bow
- Old Crown
- Imp Coping
- Analog

Dr. Signature: _____ License No. _____



SHADE **STAIN**

- Gingiva _____ None
- Body _____ Light
- Incisal _____ Medium
- Stump _____ Dark