



# DentUSA Laboratory



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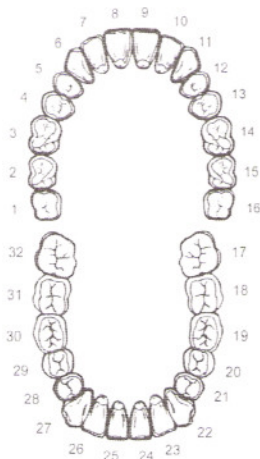
DATE DUE: \_\_\_\_\_ Dr.: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Clinic: \_\_\_\_\_

Reference # : \_\_\_\_\_ Phone: \_\_\_\_\_

<b>MATERIAL</b> Porcelain Fused on Metal <input type="checkbox"/> NP <input type="checkbox"/> Semi Noble <input type="checkbox"/> White HN <input type="checkbox"/> Yellow HN <input type="checkbox"/> Bio2000 <input type="checkbox"/> Captek <input type="checkbox"/> Titanium Full Metal Cast <input type="checkbox"/> NP <input type="checkbox"/> Yellow Gold All Ceramics <input type="checkbox"/> Empress <input type="checkbox"/> IPS Eris <input type="checkbox"/> Empress2 <input type="checkbox"/> InCeram Removable <input type="checkbox"/> RPD <input type="checkbox"/> Valplast <input type="checkbox"/> Denture <input type="checkbox"/> Ti RPD	<input type="checkbox"/> *Vita -Lumin <input type="checkbox"/> Bioform <input type="checkbox"/> Vita -3D <input type="checkbox"/> Other	<b>FINISHING</b> <input type="checkbox"/> Removal Button <input type="checkbox"/> Coping/Frame Only <input type="checkbox"/> Bisque Bake	
	<b>SHADE</b> _____ <b>OCCLUSAL STAINING</b> <input type="checkbox"/> *None <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Dark	<b>POSTERIOR METAL</b>  <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/>	<b>INTERPROXIMAL</b> Contact (vs. normal): <input type="checkbox"/> Lighter <input type="checkbox"/> Broader Embrasure (vs normal): <input type="checkbox"/> Closed <input type="checkbox"/> Wide Open
	<b>BUCCAL MARGIN DESIGN</b> <input type="checkbox"/> Porcelain But Margin <input type="checkbox"/> *Metal - Porcelain Junction Margin <input type="checkbox"/> Metal Hairline or _____ MM	<b>OCCLUSION</b> <input type="checkbox"/> *Light <input type="checkbox"/> In <input type="checkbox"/> Out	
	<b>PONTIC DESIGN</b>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/>		
If Need Occlusal Clearance: <input type="checkbox"/> Metal Occlusion <input type="checkbox"/> Reduction Coping <input type="checkbox"/> Spot Opposing			

\* Options marked with \* are standard choices unless specified otherwise.



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DOCTOR'S SIGNATURE    Enclosed With Case:  Impressions    Models    Bite    Other: