

Restorative Solutions Inc.

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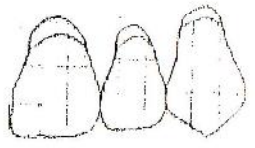
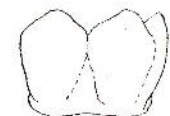
DR. NAME & PHONE # _____

PATIENT NAME _____

RETURN DATE _____ TODAY'S DATE _____

APPT. DATE & TIME _____

M / F AGE _____	
RESTORATIVE CHOICES	ALLOY
<input type="checkbox"/> ALL METAL (CAST CROWN) <input type="checkbox"/> PORCELAIN FUSED TO METAL <input type="checkbox"/> ALL CERAMIC <input type="checkbox"/> PRESSED CERAMIC <input type="checkbox"/> ZIRCONIA CAD/CAM <input type="checkbox"/> EMAX <input type="checkbox"/> IMPLANT <input type="checkbox"/> ZIRCONIA ABUTMENT <input type="checkbox"/> CAST-TO ABUTMENT IMPLANT SIZE & TYPE _____ _____ _____	<input type="checkbox"/> HIGH NOBLE YELLOW <input type="checkbox"/> HIGH NOBLE WHITE <input type="checkbox"/> NOBLE MARGIN DESIGN <input type="checkbox"/> FACIAL PORC BUTT MARGIN <input type="checkbox"/> SMALL BUCCAL COLLAR <input type="checkbox"/> METAL OCCL/ LING <input type="checkbox"/> NO EXPOSED METAL ANYWHERE <input type="checkbox"/> SMALL LINGUAL COLLAR
DIAGNOSTIC TOOLS	
<input type="checkbox"/> DIAGNOSTIC WAX-UP <input type="checkbox"/> MATRIX FOR FABRICATION OF TEMPS <input type="checkbox"/> TEMPS (6 CONTIGUOUS UNITS OR MORE ONLY) <input type="checkbox"/> ACRYLIC <input type="checkbox"/> FIBER REINFORCEMENT <input type="checkbox"/> COMPOSITE	
PLEASE RETURN CASE FOR: <input type="checkbox"/> DIE TRIM <input type="checkbox"/> METAL TRY-IN <input type="checkbox"/> BIS-BAKE TRY-IN	

SPECIAL INSTRUCTIONS	
STUMP/DENTIN SHADE: _____ <input type="checkbox"/> PLEASE CALL DOCTOR	
 	
OCCLUSAL STAIN	SURFACE TEXTURE
<input type="checkbox"/> NONE <input type="checkbox"/> LIGHT <input type="checkbox"/> DARK	<input type="checkbox"/> SMOOTH <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY
PLEASE SEND:	ENCLOSURES:
<input type="checkbox"/> MAILING BOXES <input type="checkbox"/> RX PADS <input type="checkbox"/> SHIPPING LABELS <input type="checkbox"/> BIOHAZARD BAGS	<input type="checkbox"/> BITE REGISTRATION(S) <input type="checkbox"/> IMPRESSION(S) <input type="checkbox"/> BITE FORK <input type="checkbox"/> PHOTOS / CD <input type="checkbox"/> IMPLANT PARTS <input type="checkbox"/> CUSTOM SHADE TAB <input type="checkbox"/> PRE-OP MODEL <input type="checkbox"/> OPPOSING MODEL <input type="checkbox"/> TEMP MODEL <input type="checkbox"/> OLD RESTORATIONS <input type="checkbox"/> DIAGNOSTIC WAX-UP
SIGNATURE: _____	LIC. #: _____