Rx Online CROWN & BRIDGE

Rx Date _____ Due Date _____

Dr _____

Address _____ Phone _____

City _____ Province _____

Try-In ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Finish ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Sex M ☐ F ☐

Patient's Name _____ Given Name _____ Age _____

IMAGING BEFORE & AFTER

☐ PERFORM BEFORE & AFTER
☐ USE GOLDEN PROPORTION
☐ MATCH EXISTING

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

☐ MAKE IDEAL ☐ CROWN LENGTHENING

☐ CALIBRATE IMAGE: TOOTH# _____ mm _____

☐ LORIN LIBRARY SMILE GUIDE: REF # _____

PHOTOS ATTACHED:
☐ CLOSE UP
☐ FULL FACE

DIAGNOSTIC WAX-UP / TREATMENT PLANNING

☐ PERFORM WAX-UP
☐ USE GOLDEN PROPORTION
☐ FOLLOW IMAGING

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

☐ PREP MODEL ☐ CROWN LENGTHENING

SHIFT MIDLINE ☐ YES ☐ NO RL____ mm _____ mm

PREP MATRIX ☐ YES ☐ NO OPENING VERTICAL ☐ YES _____ mm ☐ NO

TEMP MATRIX ☐ YES ☐ NO LENGTH OF CENTRALS _____ mm

INCISAL MATRIX ☐ YES ☐ NO SHIMBASHI Pre _____ mm Post _____ mm

BITE MATRIX ☐ YES ☐ NO

TYPE OF ARTICULATOR DESIRED _____ ☐ ACCULINER

INCISAL EMBRASURE _____ ☐ Rounded ☐ Square ☐ Open ☐ Closed

SHADE

SHADE _____

SYSTEM _____

☐ SHADE PHOTO ATTACHED

LADDER

STUMP SHADE		TRANSLUCENCY	
BODY SHADE		CHARACTERIZATION	
CHROMA		SURFACE ANATOMY	
VALUE			

CUSTOM CHARACTERIZATION

EXISTING SHADE

DESIRED SHADE

CASE SPECIFICATIONS

A CENTRIC CONTACT	1. FOIL RELIEF ☐	2. POSITIVE CONTACT ☐	3. CUSP FOSSA ☐	
B LATERAL EXCURSION	1. CUSPID GUIDANCE ☐	2. GROUP FUNCTION ☐		
C MARGIN ADAPTATION	1. EXACTLY TO FINISH LINE ☐	2. SLIGHT OVEREXTENSION ☐		
D LABIAL MARGIN	1. FINE GOLD COLLAR ☐	2. PORCELAIN BUTT MARGIN ☐	3. PORCELAIN TO MARGIN ☐	
E PONTIC DESIGN	1. HARMONY ☐	2. CONE ☐	3. HYGENIC ☐	4. RIDGELAP ☐
F CONTACTS (EMBRASSURES)	1. BROAD ☐	2. NORMAL ☐	3. POINT ☐	

SPECIAL MATERIALS & ALLOYS	
PRECIOUS	
SEMI-PRECIOUS	
NON-PRECIOUS	
CAPTEK	
TITANIUM	

SPECIAL TECHNIQUES & ATTACHMENTS	
SMILE DESIGN	
☐ The Smile Guide	
☐ Smile Style Guide (Lorin)	
☐ LVI	

Rx

ITEMS ENCLOSED

	QTY
IMPRESSION / BITE	
RESTORATIONS(S)	
MODELS	
ARTICULATOR	
PHOTOS ATTACHED	

Dr's signature _____

855 Broadview Ave.
Toronto, Ontario
M4K 3Z1

PRO-ART DENTAL LABORATORY LIMITED
INSTITUTE OF DENTAL TECHNOLOGY ™

Tel: (416) 469-4121
Fax: (416) 469-3258
Toll-Free: 1-800-266-6771
Web: pro-artdentallab.com

Rx online COSMETIC

Rx Date _____ Due Date _____

Dr _____

Address _____ Phone _____

City _____ Province _____

Try-In ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Finish ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Sex M ☐ F ☐

Patient's Name _____ Given Name _____ Age _____

IMAGING BEFORE & AFTER

☐ SYMMETRY BITE
☐ USE GOLDEN PROPORTION
☐ MATCH EXISTING
☐ MAKE IDEAL
☐ LVI FIXED ORTHOTIC
☐ LVI REMOVEABLE ORTHOTIC

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

☐ CROWN LENGTHENING
TOOTH # _____ mm _____
LVI SMILE GUIDE: REF # _____

PHOTOS ATTACHED:
☐ CLOSE UP
☐ FULL FACE

DIAGNOSTIC WAX-UP / TREATMENT PLANNING

☐ PERFORM WAX-UP
☐ USE GOLDEN PROPORTION
☐ FOLLOW IMAGING
☐ PREP MODEL

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

☐ CROWN LENGTHENING

SHIFT MIDLINE ☐ YES ☐ NO RL _____mm _____mm

PREP MATRIX ☐ YES ☐ NO OPENING VERTICAL ☐ YES _____ mm ☐ NO

TEMP MATRIX ☐ YES ☐ NO LENGTH OF CENTRALS _____ mm

INCISAL MATRIX ☐ YES ☐ NO SHIMBASHI Pre _____mm Post _____mm

BITE MATRIX ☐ YES ☐ NO

TYPE OF ARTICULATOR DESIRED _____ ☐ ACCULINER ☐ STRATOS

INCISAL EMBRASURE _____ ☐ Rounded ☐ Square ☐ Open ☐ Closed

SHADE

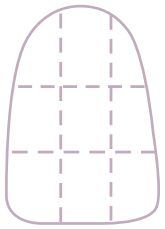
SHADE _____

SYSTEM _____

☐ SHADE PHOTO ATTACHED

STUMP SHADE		TRANSLUCENCY	
BODY SHADE		CHARACTERIZATION	
CHROMA		SURFACE ANATOMY	
VALUE		HALO	

CUSTOM CHARACTERIZATION



EXISTING SHADE

DESIRED SHADE

e-MAX Press: ☐ HT ☐ Impulse ☐ LT ☐ MO ☐ HO

CASE SPECIFICATIONS

PLEASE CHOOSE COSMETIC SYSTEM

☐ PROCERA
☐ Lava
☐ Zirconia YZ
☐ Alumina
☐ MIRAGE / FORTRESS
☐ e-MAX
☐ e-MAX Zir Press
☐ e-MAX/CAD
☐ Prestige
☐ Other: _____
☐ Vita VM 7
☐ CREATION
☐ CERAMAGE
☐ SCULPTURE PLUS

Rx

Dr's signature _____

ITEMS ENCLOSED

	QTY
IMPRESSION / BITE	
RESTORATIONS(S)	
MODELS	
ARTICULATOR	
PHOTOS ATTACHED	

PRO-ART STHETIC DENTAL LABORATORY LIMITED
INSTITUTE OF DENTAL TECHNOLOGY ™
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Rx Online IMPLANTS

Rx Date _____ Due Date _____

Dr _____

Address _____ Phone _____

City _____ Province _____

Try-In ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Finish ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Patient's Name _____ Given Name _____ Sex M ☐ F ☐ Age _____

DIAGNOSTIC WAX-UP AND TREATMENT PLANNING

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

☐ STUDY MODELS / XRAYS / PHOTOS

☐ FULL COUNTOUR WAX-UP OF MISSING TEETH

☐ TREATMENT PLANNING PHOTO ATTACHED

☐ RADIOGRAPHIC STINT TYPE _____

☐ SURGICAL STINT ☐ NOBEL GUIDE ☐ SIMPLANT

SYSTEMS

PLEASE CHOOSE IMPLANT SYSTEM

☐ NOBEL BIOCARE ☐ STRAUMANN ☐ 3i

☐ BIOHORIZONS ☐ INNOVA ☐ ZIMMER

☐ ASTRA TECH ☐ BICON ☐ Other: _____

RESTORATIVE MATERIALS

☐ CERAMIC ☐ GOLD ☐ SEMI-PRECIOUS ☐ TITANIUM

PRODUCTS

☐ SINGLE TOOTH ☐ CROWN & BRIDGE IMPLANT ☐ FIXED DETACHABLE

☐ OVERDENTURE ☐ PROCERA BRIDGE ☐ TEETH-IN-1-HOUR

☐ MILLED BAR WITH ATTECHMENTS ☐ MILLED DOUBLE BAR

☐ CUSTOM ABUTMENT Specify _____

SHADE

SHADE _____

SYSTEM _____

☐ SHADE PHOTO ATTACHED

CUSTOM CHARACTERIZATION

EXISTING SHADE

DESIRED SHADE

LADDER

STUMP SHADE		TRANSLUCENCY	
BODY SHADE		CHARACTERIZATION	
CHROMA		SURFACE ANATOMY	

CASE SPECIFICATIONS

Rx

ITEMS ENCLOSED

	QTY
IMPRESSION COPINGS	
IMPRESSION / BITE	
RESTORATIONS(S)	
MODELS	
ARTICULATOR	
PHOTOS ATTACHED	

Dr's signature _____

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Web: pro-artdentallab.com

Rx Online REMOVABLE

Rx Date _____ Due Date _____

Dr _____

Address _____ Phone _____

City _____ Province _____

Try-In ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Finish ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Sex M ☐ F ☐

Patient's Name _____ Given Name _____ Age _____

MOULD & SHADE SPECIFICATIONS

Anteriors	Porcelain ☐	Plastic ☐	Shade _____	Mould _____	
Posteriors	Porcelain ☐	Plastic ☐	Shade _____	Mould _____	
	Rational ☐	Functional ☐	Twenty Degree (20°) ☐	Thirty-Three Degree (33°) ☐	

Brand of teeth to be used: _____

FACIAL CHARACTERISTICS

Check Basic Face Form

Square ☐ Square Tapering ☐ Tapering ☐ Ovoid ☐

Check Facial Asymmetry

Dominant Right Side ☐ Dominant Left Side ☐ Male ☐ Female ☐ Vigorous ☐ Soft ☐

SYSTEMS

ACRYLIC

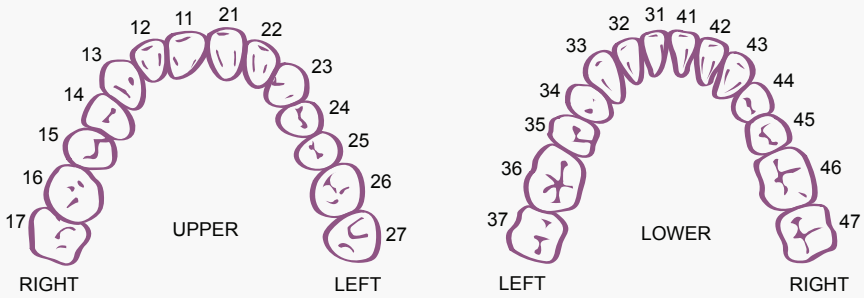
- ☐ PRIME DENTURESS (Dr. Carlson)
- ☐ BPS Ivocap
- ☐ LUCITONE 199
- ☐ VALPLAST
- ☐ THERMOFLEX
- ☐ FLEXITE
- ☐ ECLIPSE
- ☐ ENIGMA

METAL

- ☐ VITALLIUM 2000
- ☐ TITANIUM
- ☐ GOLD

SPECIAL TECHNIQUES & ATTACHMENTS	

DESIGN CASE



Rx

ITEMS ENCLOSED

	QTY
IMPRESSION / BITE	
RESTORATIONS(S)	
MODELS	
ARTICULATOR	
PHOTOS ATTACHED	

Dr's signature _____

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Rx Online ORTHO

Rx Date _____ Due Date _____

Dr _____

Address _____ Phone _____

City _____ Province _____

Try-In ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Finish ☐ Date Required _____ Time Wanted _____ a.m. [ ] p.m. [ ]

Sex M ☐ F ☐

Patient's Name _____ Given Name _____ Age _____

SPECIFICATIONS

ARCH EXPANDERS	UPPER	LOWER
ALF Appliance	☐	☐
Twin Block Appliance	☐	☐
Crozat Appliance	☐	☐
Saggittal	☐	☐
To Distalize Posterior	☐	☐
To Advance Anterior	☐	☐
3-Way	☐	☐
CL III	☐	☐
Schwartz	☐	☐

HAWLEY	UPPER	LOWER
Hawley Retainer with Adams Clasps	☐	☐
Wrap Around Retainer	☐	☐
Hawley Retainer with C-Clasps	☐	☐
San Antonio Retainer	☐	☐
Other _____		

SPRING RETAINERS	UPPER	LOWER
Anterior Spring Retainer	☐	☐
Spring Retainer with Wire Extensions	☐	☐
Hawley Spring Retainer	☐	☐

HABIT	UPPER	LOWER
Thumb Habit Appliance	☐	☐
Tongue Habit Appliance	☐	☐
Lower Fixed Sagittal		☐
Direct Bond Rapid Palatal Expander	☐	☐

TOOTH POSITIONER	UPPER	LOWER
Please Specify _____	☐	☐

MODELS	UPPER	LOWER
Duplicate Model	☐	☐
Study Model	☐	☐
Soap Ortho Model	☐	☐
Non-Soap Ortho Model	☐	☐

SPORT GUARDS	UPPER	LOWER
Athletic Mouth Guard	☐	☐
Pro-Form Mouth Guard	☐	☐
Hockey Mouth Guard	☐	☐
Boxing Mouth Guard	☐	☐

ANTI SNORING	UPPER	LOWER
Twin Block Appliance	☐	☐
Tongue Positioner	☐	☐
Easy Sleep		

ORTHOTICS	UPPER	LOWER
Diagnostic Appliences	☐	☐
Carlson Diagnostic Applience	☐	☐
Soft Pivot Applience		
Treatment Appliences	☐	☐
ALF Twin Block Applience	☐	☐
Thong Applience	☐	☐
King Thong Applience	☐	☐
King Thong Crystobal Process	☐	☐
Eclipse Orthotic	☐	☐
Thermoflex Orthotic	☐	☐
Overlay Orthotic Crystabol		

GUARDS: NIGHT/BLEACHING	UPPER	LOWER
Nigh Guard (Hard)	☐	☐
Im-Pak Semi-Soft Night Guard	☐	☐
Ivocap Night Guard	☐	☐
Elastomer Night Guard	☐	☐
Eclipse Night Guard	☐	☐
Dual Layer Night Guard	☐	☐
Bite Plane Opener	☐	☐
Bleaching / Flouride Guards	☐	☐

TEETH TO BE RESET

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

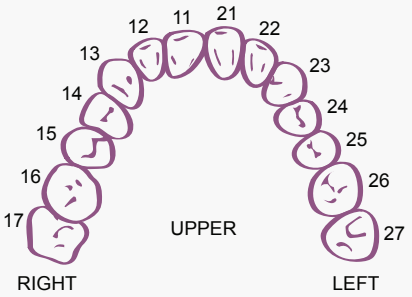
IMAGING BEFORE & AFTER

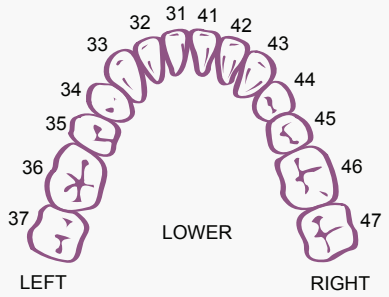
☐ PERFORM BEFORE & AFTER :
☐ MAKE IDEAL

PHOTOS ATTACHED:
☐ CLOSE UP
☐ FULL FACE

17 16 15 14 13 12 11	21 22 23 24 25 26 27
47 46 45 44 43 42 41	31 32 33 34 35 36 37

DESIGN CASE





TYPE OF ARTICULATOR DESIRED _____

ITEMS ENCLOSED	QTY
IMPRESSION / BITE	
RESTORATIONS(S)	
MODELS	
ARTICULATOR	
PHOTOS ATTACHED	

Dr's signature _____

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LABIAL INDIRECT BONDING / Rx

☐ PHONE ME REGARDING THIS CASE ☐ SPECIAL INSTRUCTIONS ON FILE ☐ NEW ACCOUNT ☐ ADDRESS CHANGE	SEND ADDITIONAL ☐ RX SHEETS ☐ MAILING LABELS

SPECIALTY APPLIANCES
ORTHODONTIC LABORATORY SERVICES

Doctor _____

Address _____

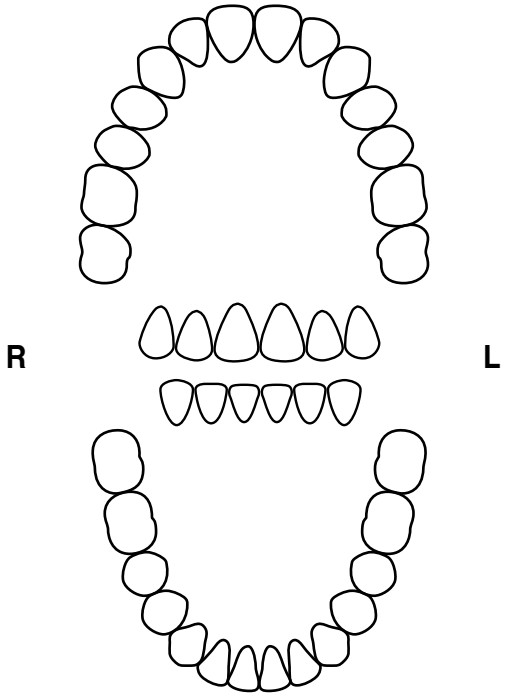
City _____ State _____ Zip _____

Telephone _____ Fax _____

Patient Name _____

Date Shipped _____

Date Needed _____



CASE INFORMATION

☐ Upper ☐ Lower ☐ .018 ☐ .022
☐ Custom Base System ☐ Clean Base Method
☐ Brackets Enclosed with Case ☐ Specialty Provide Brackets

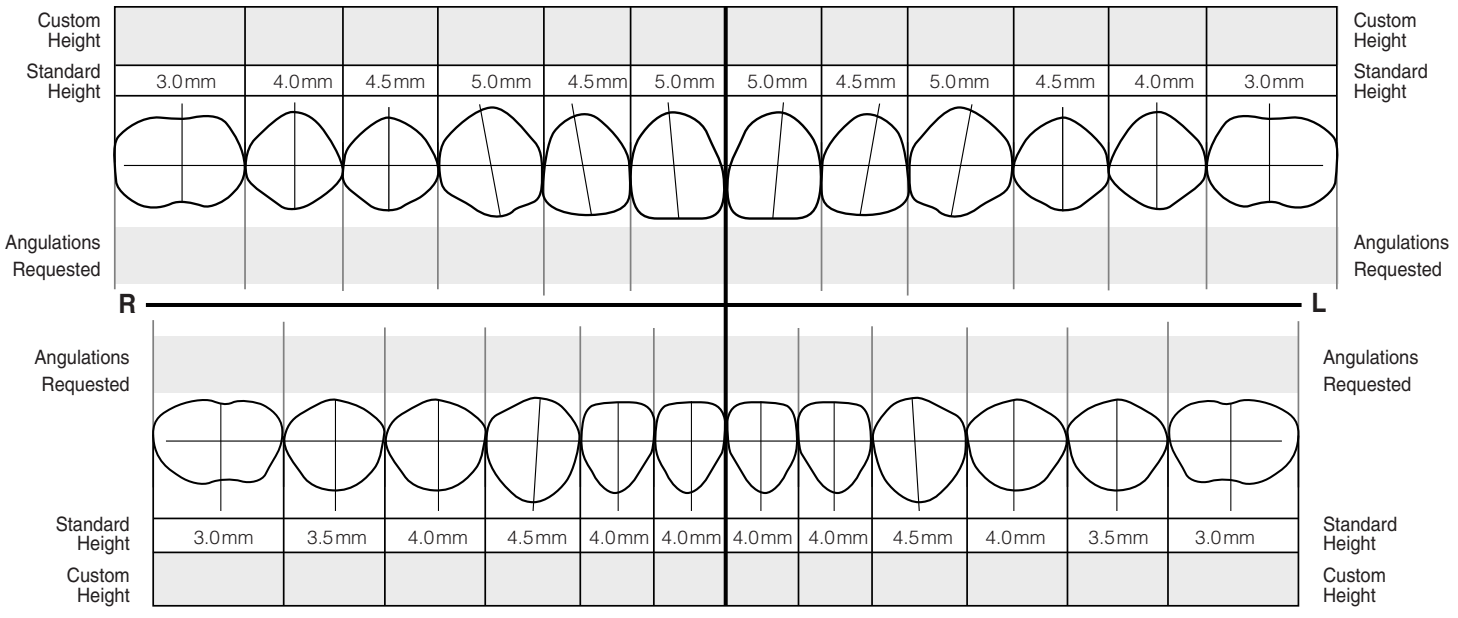
TRANSFER TRAYS

☐ Full Arch ☐ Midline Split ☐ 3 Piece
☐ Clear Formed Trays ☐ Silicone Trays

Please Indicate on Diagram to Right

1. Mark an "X" on teeth missing, to be extracted, or those not to be bonded
2. Indicate with arrows over-rotations desired

BRACKET HEIGHT AND ANGULATION PRESCRIPTION - See Reverse for Further Explanations and Details



8-02

SPECIAL INSTRUCTIONS _____

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