



IMPLANTS

Rx Date _____ Due Date _____
 Dr _____
 Address _____ Phone _____
 City _____ Province _____
 Try-In Date Required _____ Time Wanted _____ a.m. []
 Finish Date Required _____ Time Wanted _____ p.m. []
 Patient's Name _____ Given Name _____ Sex M F
 Age _____

DIAGNOSTIC WAX-UP AND TREATMENT PLANNING

STUDY MODELS / XRAYS / PHOTOS _____ 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
 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 _____

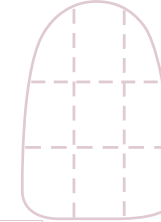
SHADE

SHADE _____

SYSTEM _____

SHADE PHOTO ATTACHED

CUSTOM CHARACTERIZATION



EXISTING SHADE



DESIRED SHADE



LADDER

STUMP SHADE		TRANSLUCENCY	
BODY SHADE		CHARACTERIZATION	
CHROMA		SURFACE ANATOMY	

CASE SPECIFICATIONS



ITEMS ENCLOSED

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

Dr's signature _____

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