



8155 E. Indian Bend Rd., Suite 101 • Scottsdale, AZ 85250
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 www.dentekdental.com • www.facebook.com/dentekdentalaz



Dr. and Patient Information

Dr.: _____

Address: _____

City/State/Zip: _____ Phone: _____

Patient: _____ Age: _____ Gender: M F

LAB USE ONLY

PAN #

SHIP DATE

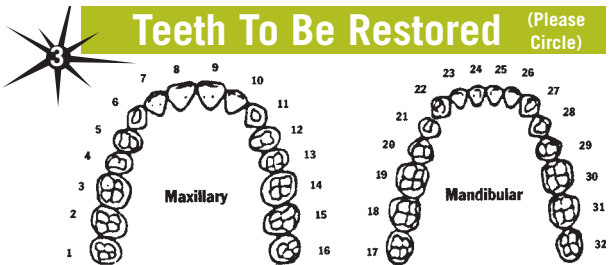
SCANNED

DUE DATE

Due by 5:00 P.M. on:

PLEASE CALL DOCTOR
UPON RECEIPT OF THIS
CASE TO DISCUSS

Teeth To Be Restored (Please Circle)



Material Selection

ZIRCONIA

- VivaZir** Monolithic Zirconia
- Layered Crown/Bridge
- Press to Zirconia Stained
- Press to Zirconia Layered
- Inlay Bridge
- Maryland Bridge

EMPRESS ESTHETIC

- Inlay/Onlay
- Crown/Veneer - Stained
- Crown/Veneer - Layered

E..MAX

- Layered Crown/Bridge
- Full Contour Pressed
- No Prep Veneer

OTHER SERVICES

- Diagnostic Wax-up
- Long Term Temporaries
- Custom Tray

PORCELAIN TO METAL

SELECT A METAL

- Noble/Semi Precious
- High Noble White
- High Noble Yellow
- Bio2000 99.7%Ag
- Chrome Cobalt
- Titanium

SELECT BUILD UP

- Layered Crown/Bridge
- Press Over Metal

MARGIN DESIGN

- Porcelain Butt Margin
 - 180° 360°
- Metal Collar
- Metal Occlusal /Lingual

MICRO-CERAMIC COMPOSITE

- Inlay/Onlay
- Metal Free Crown
- Metal Supported Crown/Bridge

CAST/MILLED

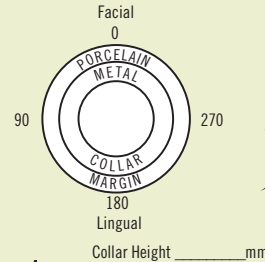
- Cast Inlay/Onlay
- Cast Crown/Bridge
- Milled Chrome Cobalt
- Milled Grade 5 Titanium

IMPLANTS

- Brand _____
 Size _____
- Stock Abutment
 - Titanium
 - Zirconia
 - STREAMLINE**
CUSTOM ABUTMENTS
 - Titanium
 - Hybrid
 - Shaded Hybrid
 - Zirconia
 - Implant Surgical Stent

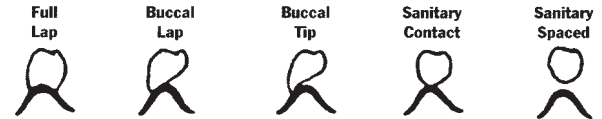
MARGIN DESIGN

PLEASE SHADE IN MARGIN DESIGN



PONTIC DESIGN

PLEASE CIRCLE PONTIC DESIGN



Natural Die Shade (Please Circle)

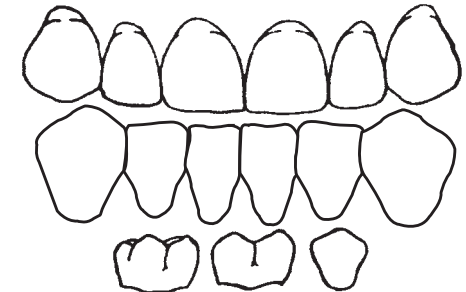
*Natural die shades are **REQUIRED** for all ceramic restorations.
ND1 ND2 ND3 ND4 ND5 ND6 ND7 ND8 ND9

Characterization

SHADE: _____

CUSTOM SHADE IN LAB

	None	Light	Med	Heavy
Occlusal Stain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incisal Translucency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mammelon Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypocalcification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surface Texture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Specific Instructions

Dentist Information

DENTIST LICENSE NUMBER: _____ DATE: _____

TERMS: Net 30 days. 2% per month service charge on unpaid balance 30 days after statement, C.O.D. + 25% of remaining balance with each new case. Doctors agree to pay reasonable attorney and legal expenses required if collection becomes necessary.

Personal Signature of Dentist (Required)

PLEASE SEND THE FOLLOWING:

- Mailing Boxes
- Delivery Bags
- Biohazard Bags
- Rx Forms
- Shipping Labels