



DOCTOR \_\_\_\_\_

M or F

PATIENT'S NAME \_\_\_\_\_

SHADE \_\_\_\_\_

CUSTOM SHADE \_\_\_\_\_

**DOCTOR'S DUE DATE**

(1-6 UNITS REQUIRE 12 WORK DAYS)

**DR.'S SIGNATURE**

**LICENSE #**

**STATE**

**DATE**

(Please construct & deliver to me the dental restoration described herein.)



IPS EMPRESS®

IPS E.MAX®

ZIRCONIA®

FULL GOLD CROWN/s (FGC )

yellow

IMPLANT RESTORATION

DENTURE  BLEACHING TRAY

REPAIR  RELINE

DIAGNOSTIC WAX-UP

**NOTES:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Basic Shade: \_\_\_\_\_ Stump Shade: \_\_\_\_\_ Shade Guide Used: \_\_\_\_\_

