Pan# _____

Dr# _____

Date _____

Gold Dust DENTAL LAB

AESTHETIC PRESCRIPTION

Doctor _____ Requested Return Date _____

Address _____ E-mail _____

City _____ State _____ Zip _____ Phone _____

Patient _____ M/F _____ Age _____

Clinical Goals of Case:

☐ Close Diastema ☐ Lengthen Teeth ☐ Change Shape ☐ Establish Function

☐ Corridor Expansion ☐ Move Midline ☐ Other: _____

☐ VDO Changes: *Please call lab to discuss sequence of treatment planned*

Case Directions:

☐ Follow Study Models ☐ Follow Wax-up ☐ Occulsal Analysis

☐ Length of Centrals _____ ☐ Length of Laterals _____

☐ Teeth to be Restored: _____

Materials Selection:

Pressed Ceramics:

☐ Empress Esthetic Teeth # _____

☐ e.Max Teeth # _____

☐ e.Max Zirpress to ☐ Lava or ☐ 3M Essential Zirconia Teeth # _____

☐ Emprethins ☐ EmpreShades Teeth # _____

☐ Pressed-Over-Metal Teeth # _____

Stacked Ceramics:

☐ PSZ (Porcelain Stacked over Zirconia) ☐ Lava or ☐ 3M Essential Zirconia Teeth # _____

☐ PFM ☐ Bio PF ☐ Gold 40% ☐ Non-Precious Teeth # _____

☐ Refractory Veneers Teeth # _____

☐ Wax Up ☐ Wax Up Kit ☐ Custom Trays Teeth # _____

Articulator

☐ Stratos ☐ Panadent ☐ Sam 3 ☐ Artex ☐ Kavo ☐ Denar ☐ Other

Items Included With Case:

☐ Opposing Impression or Model ☐ Bite Registration w/ stick _____ ☐ Photos - Qty. _____

☐ Model or Impression of Provisionals ☐ Bite Registration w/o stick ☐ Media Card _____

☐ Master Impression - Qty. _____ ☐ Facebow ☐ CD/DVD _____

☐ Diagnostic Wax-up ☐ Incisal Edge Index ☐ Photos Email on (date): _____

☐ Pre-operative models _____ ☐ CR Bite ☐ CO Bite ☐ Other

Terms: Balances not paid within 30 days of statement are subject to a delinquency charge. Accounts that become 45 days past due will be placed on C.O.D., and a portion of the remaining balance will be added to each case delivered thereafter. The dentist will be responsible for all collection costs including attorney's fees incurred in the event that account collection becomes necessary.

Dentist's Signature _____

License # _____ Date _____

Gold Dust Dental, Inc. • 2242 S. McClintock, Suite 1 • Tempe, Arizona 85282
(480) 968-6131 • 1-800-513-6131 • FAX(480) 968-8831 • E-MAIL: info@golddustdental.com

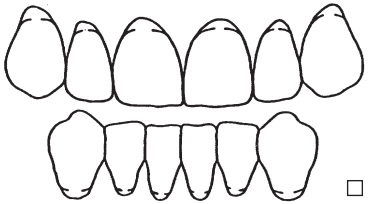
Shade:

☐ Cervical Shade: _____

☐ Body Shade: _____

☐ Incisal Shade: _____

☐ Occlusal Stain: _____



☐ Diagrams to Follow

Preparation Shade with tooth #: _____

☐ See Preparation Shade photo for details

CEJ - CEJ: # _____ to # _____ Preop _____ mm Final _____ mm

Length Desired From Margin: Centrals _____ mm Laterals _____ mm Canines _____ mm

Smile Design: Guide Used _____ **Style** _____

Pontic Design _____

Other Shade & Finish Information:

Incisal Translucency: ☐ Minimal (0.5mm) ☐ Moderate (1.0mm) ☐ Maximum (1.5mm)

Shade of Translucency: ☐ Clear ☐ Frosted ☐ Amber

Surface Texture: ☐ High ☐ Medium ☐ Light ☐ Smooth

Surface Morphology: ☐ Heavy ☐ Medium ☐ Light ☐ Smooth

OK to relieve opposing? ☐ YES ☐ NO _____ OK to relieve prep? ☐ YES ☐ NO ☐ w/Reduction Coping _____

Preferred method of communication: ☐ Phone ☐ E-mail

Additional Information:

For General Restorative Rx go to www.golddustdental.com or to submit online go to www.golddustdental.com and select Client Services.

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5/3/10

Pan# _____

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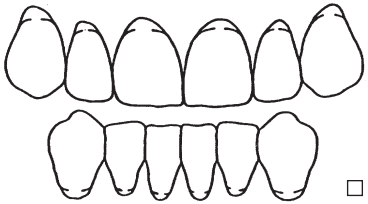

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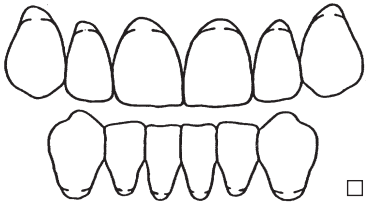

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