Pan# _____

Dr# _____

Date _____

Gold Dust DENTAL LAB

IMPLANT Rx

Doctor _____ Requested Return Date _____

Address _____ E-mail _____

City _____ State _____ Zip _____ Phone _____

Patient _____ M/F _____ Age _____

Implant Reference: Size _____ Brand _____

IMPLANT PACKAGE

☐ **CEMENT-RETAINED RESTORATIONS**

Material

- ☐ Non-Precious PFM
- ☐ White High Noble PFM
- ☐ IPS e.max
- ☐ Zirpress e.max
- ☐ Zirconia

☐ **SCREW-RETAINED RESTORATIONS**

Material

- ☐ Non-Precious PFM
- ☐ White High Noble PFM
- ☐ IPS e.max
- ☐ Zirpress e.max
- ☐ Zirconia

• SELECT RESTORATION TYPE

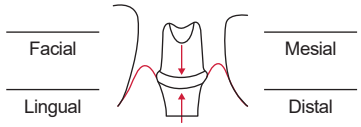
☐ Crown ☐ Splinted Crowns ☐ Bridge

• ABUTMENT SELECTION

- ☐ Gold Hue
- ☐ Titanium abutment
- ☐ Zirconia abutment
- ☐ Tibase to zirconia abutment
- ☐ Hybrid Zirconia with pink porcelain:
  Gingival Shade _____

Implant Package Includes: Gold Hue, Final Screw, Soft Tissue Model, Shipping & Handling

ABUTMENT MARGIN DEPTH



** If left blank, default values will be used (Defaults: Facial: -1mm, Mesial: -0.75mm, Distal: -0.75mm, Lingual: -0.5mm)*

ABUTMENT EMERGENCE PROFILE

☐ Surgical Placement ☐ Tissue Displacement* ☐ No Tissue Displacement

** If left blank, default (Tissue Displacement) will be used.*

Items Included With Case:

Master Impression - Qty._____ ☐ Media Card _____

☐ Opposing Impression or Model ☐ Pre-operative models _____ ☐ CD/DVD_____

☐ Model or Impression of Provisionals ☐ Photos - Qty._____ ☐ Photos Email on(date):_____

Scan Submitted With: ☐ Cerec Connect ☐ 3Shape Trios ☐ ITero ☐ Lava C.O.S. _____ date

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

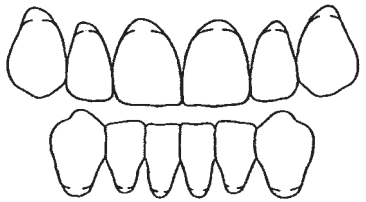
Dentist's Signature _____

License # _____ Date _____

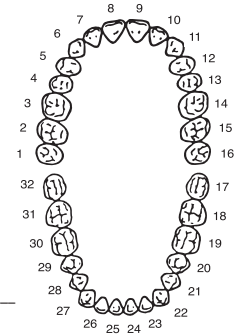
Gold Dust Dental, Inc. • 2242 S. McClintock, Suite 1• Tempe, Arizona 85282
(480) 968-6131 • 1-800-513-6131 • FAX (480) 968-8831 • E-MAIL: rx@golddustdental.com

Shade:

- ☐ Cervical Shade: _____
- ☐ Body Shade: _____
- ☐ Incisal Shade: _____
- ☐ Occlusal Stain: _____



Circle Teeth #'s to be Restored



Preparation Shade with tooth #: _____

☐ See Preparation Shade photo for details

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

LengthDesired 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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