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

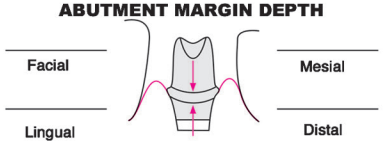
☐ Crown ☐ Splinted Crowns ☐ Bridge

• ABUTMENT SELECTION

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

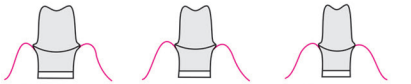
Implant Package Includes: Gold Hue, Final Screw, Soft Tissue Model, Shipping & Handling

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:

- ☐ Opposing Impression or Model
- ☐ Model or Impression of Provisionals
- ☐ Custom Impression Copings - Qty. _____
- ☐ Master Impression - Qty. _____
- ☐ Pre-operative models _____
- ☐ Photos - Qty. _____
- ☐ Media Card _____
- ☐ CD/DVD _____
- ☐ Photos Email on (date): _____

Scan Submitted With: ☐ ITero ☐ 3Shape Trios ☐ Cerec Connect ☐ 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 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.

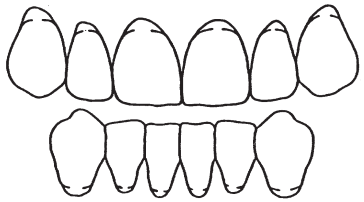
Dentist's Signature _____

License # _____ Date _____

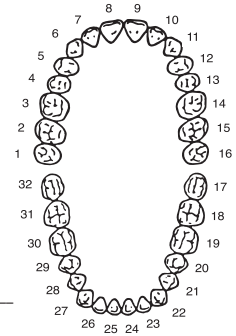
Gold Dust Dental, Inc. • 2242 S. McClintock, Suite 1 • Tempe, Arizona 85282
(480) 968-6131 • 1-800-513-6131 • FAX (480) 968-8831 • E-MAIL: rx@golddustdental.com

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

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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