



FRONTIER DENTAL LABORATORIES

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**DETERMINE DELIVERY DATE:* (SCHEDULE YOUR PATIENT AT LEAST 14 DAYS FROM TODAY.)
DATE YOU ARE MAILING THIS CASE + 14 DAYS = DELIVERY DATE

DELIVERY BY 5:00 P.M.

DOCTOR'S NAME _____
PATIENT'S NAME _____
OFFICE ADDRESS _____

OFFICE PHONE _____
EMAIL ADDRESS _____

1. RX TOOTH #
ALL CERAMIC [EMPRESS _____
AUTHENTIC _____
EMAX EPRESS (LITHIUM DISILICATE) _____
ZIRCONIA _____
PROCERA _____
FELDSPATHIC _____
PORCELAIN TO METAL [P.F.G. _____
AUTHENTIC W/METAL _____
BIO 2000 (24K) _____
CAPTEK _____
CEROMERS/COMPOSITES [SINFONY _____
SINFONY/VECTRIS _____
ALL METAL [GOLD CROWN 62% _____
GOLD 77% II _____

R_x - INSTRUCTIONS _____

 ADDITIONAL INSTRUCTIONS ATTACHED (CONTINUED OVERLEAF)

INCOMING CHECK LIST
 IMPRESSION/MASTER
 OPPOSING
 BITE
 STICK BITE
 PICTURES/SLIDES/CD
 OLD CROWN
 STUDY MODELS
 OLD MODELS
 FACE BOW
 IMPLANT IMPRESSION COPINGS
 IMPLANT ANALOG
 IMPLANT ABUTMENTS
 DIAGNOSTIC WAX UP
 ARTICULATOR _____
 PARTIAL _____

IF INADEQUATE CLEARANCE: SPOT DIE OPPOSING NOTIFY DOCTOR
PORCELAIN BUTT MARGINS TOOTH # _____

2. SHADE OF PREPARATION
STUMP SHADE TEETH #S _____ ST _____
STUMP SHADE TEETH #S _____ ST _____
STUMP SHADE TEETH #S _____ ST _____

3. LENGTH OF CENTRALS TO SOFT TISSUE ZENITH
#8 _____ #9 _____
SPECIAL LENGTH INSTRUCTIONS _____

4. SMILE DESIGN
 SMILE GUIDE DORFMAN PAGE _____ STYLE _____
 SMILE CATALOG L.V.I. _____
 CHICHE "SMILE DESIGN" PAGE _____
 MATCH PHOTOS, MAGAZINE, ETC. _____
 FOLLOW WAX UP FOLLOW TEMPS/MOCKUP

5. INCISAL TRANSLUCENCY
 MINIMAL .5 MODEST 1.0 MAX 1.5
AOSHIMA PAGE _____ # _____
UBASSY ANALYSIS PAGE _____
CHICHE "SMILE DESIGN" PAGE _____

6. RIDGE RELIEF YES NO
OVATE MM. FULL LAP BUCCAL LAP SANITARY CONTACT SANITARY SPACED

PLEASE SEND: MAILING BOXES RX FORMS MAILING LABELS

7. SURFACE TEXTURE
 HIGH MEDIUM LIGHT
 SMOOTH (NO TEXTURE)
 AOSHIMA PAGE _____ # _____
8. SURFACE FINISH
 HIGH GLAZE
 POLISHED GLOSS
 SATIN FINISH
 LOW GLOSS
 AOSHIMA PAGE _____ # _____
9. LIGHT SOURCE USED
 OPERATORY FLUORESCENT
 NATURAL SUNLIGHT
 OTT LIGHT
 OTHER _____
10. INGOT CHOICE (OPTIONAL)
 E01 (EMPRESS)
 E02 (EMPRESS)
 ETC1 (EMPRESS)
 W+ (AUTHENTIC)
 OTHER _____

SHADE GUIDE _____
TAB # CIRCLE WHAT PART OF TAB
NECK
CERVICAL
DENTIN GINGIVAL
DENTIN MID BODY
INTER PROXIMAL
INCISAL
INCISAL EDGE

SHADE NOTES _____

LABORATORY CHECK LIST FOR DOCTOR'S OFFICE
 SHADE OF PREPARATIONS (STUMP SHADE) SHADE OF ALL TEETH
 LENGTH OF CENTRALS TO SOFT TISSUE OPPOSING MODEL
 SMILE DESIGN WORKING IMPRESSIONS
 BITE REGISTRATION WITH STICK SLIDES OR PRINTS
 BITE REGISTRATION WITHOUT STICK INCISAL MATRIX

DENTIST'S SIGNATURE _____ LICENSE # _____ DATE _____
I AGREE TO TERMS ON REVERSE SEE BACK OF RX FOR ADDITIONAL INFORMATION

