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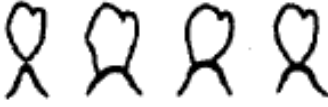
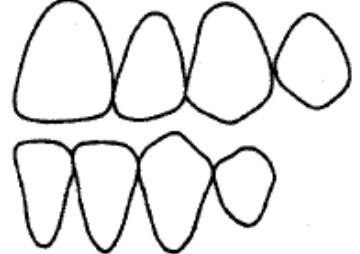
FIXED PROSTHETIC PRESCRIPTION

DR'S NAME _____ DR'S PHONE _____

ADDRESS _____ City _____ State _____ Zip _____

PATIENT (Last) _____ (First) _____ Age _____ Sex _____

DELIVER BY Date _____ Time _____

<p>All Ceramic Restoration</p> <p><input type="checkbox"/> Emax <input type="checkbox"/> Empress</p> <p><input type="checkbox"/> Porcelain Fused to Zirconia</p> <p><input type="checkbox"/> Full Zirconia</p>	<p>Framework/Coping Design</p> <p><input type="checkbox"/> Porcelain Butt Joint Margin</p> <p><input type="checkbox"/> Metal/Zirc M.D.L. Collar</p> <p><input type="checkbox"/> 360° Metal/Zirc Collar</p> <p><input type="checkbox"/> Porcelain Covering to Edge</p>
<p><input type="checkbox"/> Porcelain Fused to Metal</p> <p><input type="checkbox"/> Full Cast Crown</p> <p><input type="checkbox"/> Yellow High Noble <input type="checkbox"/> White High Noble</p>	<p>If No Occlusal Clearance</p> <p><input type="checkbox"/> Relieve Opposing</p> <p><input type="checkbox"/> Metal/Zirc Occlusal</p> <p><input type="checkbox"/> Metal/Zirc Island</p> <p><input type="checkbox"/> Prep Reduction Coping</p>
<p>Removable</p> <p><input type="checkbox"/> Bite Splint <input type="checkbox"/> Provisional RPD</p>	
<p>Pontic Design</p> <p></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Occlusal Stain: _____</p> <p>Texture: _____</p> <p>Stump Shade: _____</p> <p>Shade: _____</p> 

Instructions: _____

Dentist's Signature _____ License # _____