

Instructions:

- Complete form in 2 copies
(keep bottom copy, send 1 with the job)

Type of Restoration <ul style="list-style-type: none"> <input type="checkbox"/> Crown <input type="checkbox"/> Bridge <input type="checkbox"/> Inlay/Onlay <input type="checkbox"/> Veneer <input type="checkbox"/> Maryland wing <input type="checkbox"/> Post/Core <input type="checkbox"/> Buccal Porcelain Margin <input type="checkbox"/> All-round Porcelain Margin <input type="checkbox"/> Fine Metal Margin <input type="checkbox"/> Metal palatal / lingual / occlusal 		Enclosed in Package Study Models _____ Alginate _____ Rubber _____	Impression Disinfected and dry: <input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluation Box _____ _____	Practitioner _____ Practice _____ Address _____ _____ Tel. No. _____																	
Most Popular Products/Materials: <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left;">Standard Quality</th> <th style="text-align: left;">*Private Quality</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Non-precious PFM</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> IPS e.max Crown/Bridge</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> IPS e.max Monolith</td> <td>N/A</td> </tr> <tr> <td><input type="checkbox"/> E.max Cad/Cam</td> <td>N/A</td> </tr> <tr> <td><input type="checkbox"/> Layered Zirconia</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Monolith Zirconia</td> <td>N/A</td> </tr> <tr> <td><input type="checkbox"/> Implant - cement retained</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Implant - screw retained</td> <td><input type="checkbox"/></td> </tr> </tbody> </table>	Standard Quality	*Private Quality	<input type="checkbox"/> Non-precious PFM	<input type="checkbox"/>	<input type="checkbox"/> IPS e.max Crown/Bridge	<input type="checkbox"/>	<input type="checkbox"/> IPS e.max Monolith	N/A	<input type="checkbox"/> E.max Cad/Cam	N/A	<input type="checkbox"/> Layered Zirconia	<input type="checkbox"/>	<input type="checkbox"/> Monolith Zirconia	N/A	<input type="checkbox"/> Implant - cement retained	<input type="checkbox"/>	<input type="checkbox"/> Implant - screw retained	<input type="checkbox"/>	Special Instructions _____ _____	Tooth for Restoration 	Shade 	Patient Name _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Fit Date _____ <small>(Please try to allow ten working days due to postal delays)</small> Fit Have you remembered the shade?
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<p>*Private Quality</p> Using only our best technicians. See our website for more details.	Preferred Design of Pontic <div style="display: flex; justify-content: space-around; text-align: center;"> <div> Ridge Lap</div> <div> Modified Ridge Lap</div> <div> Hygienic</div> <div> Cone</div> <div> Socket Ovate</div> </div>	Practitioner's Signature _____ (Signature) Date : _____	For Office Use Job No. _____ _____ Inspecting Technician																			
The Registration number of the manufacturer with the MHRA is CA014485 This is a custom-made device for the exclusive use of the patient and conforms to the relevant essential requirements as set out within Appendix 1 of the MHRA Directive (93/42/EEC). Relevant essential requirements not met and reasons why are listed in the evaluation box.					Warning: Keep device from extraordinary heat or cold. Do not drop or crush. Fragile!																	

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Type of Restoration

Trays & Bite Blocks

OS01A Special Tray

OS01B Bite Block

OS01S Combined Tray/Bite Block

Acrylic Dentures

AD01NT Acrylic Partial / Denture

CCMS Mesh Strengtheners

ADSOFT Soft Liner

RELINE

Valplast Flexible Dentures

AD02NT Valplast Partial

Shade

Shade..... 

Metal Frameworks

VPDF Vitallium Framework

CCFO Chrome Cast Framework

TTFO Titanium Framework

Finishing

Acrylics & Valplast:

Teeth set in wax for try in

Go to finish

Metal dentures:

Framework only

Teeth set in wax for try in

Acrylic base/Teeth added - go to finish

Enclosed in Package

Impression Disinfected Yes No

	<u>Quantity</u>	<u>Received by HS</u>
Study Models	_____	_____
Alginate	_____	_____
Rubber	_____	_____

Evaluation Box

Practitioner _____

Practice _____

Address _____

Special Instructions

Tel. No. _____ : _____
(area code) (number)

Patient Name _____

Age _____ Male Female

Fit Date _____

Practitioner's Signature

(Date)

For Office Use

Job No. _____

Inspecting Technician _____

The Registration number of the manufacturer with the MHRA is CA014485

This is a custom-made device for the exclusive use of the patient and conforms to the relevant essential requirements as set out within Appendix 1 of the MHRA directive (93/42/EEC).

Relevant essential requirements not met and reasons why are listed in the evaluation box.

Warning: Do not drop or crush. Fragile! Keep device from extraordinary heat or cold.

Circle teeth required

Upper Right										Upper Left							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28		

Lower Right								Lower Left									
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38		

