

### Step 1- Dentist & Patient Information

Restorative Dr. Name \_\_\_\_\_ (REQUIRED) Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_  
 Surgical Dr. Name \_\_\_\_\_ (REQUIRED) Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_  
 Patient Name \_\_\_\_\_ (REQUIRED)  Male  Female

Today's RX Date \_\_\_\_\_  
 Bill to Doctor: \_\_\_\_\_  
 Phone : \_\_\_\_\_

*Please bill this doctor for restoration and/or services provided. I understand that the lab will contact this doctor prior to starting case, to confirm billing.*

### Step 2 - Delivery Logistics

**Delivery of Phase 1:**  Surgical Practice  Restorative Practice **Due Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Surgery Start Time:** \_\_\_\_:\_\_\_\_  
**Delivery of Try-in:**  Surgical Practice  Restorative Practice **Due Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Delivery Time: 3:00**  
**Delivery of Restoration:**  Surgical Practice  Restorative Practice **Due Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Delivery Time: 3:00**

*Surgeon should be ready for chairside technician no later than 11:30 to approve abutment placement and to assist in record capturing.*

*This is an optional appointment. It is recommend that dual arches be try-in prior to finishing. Additional fees apply for the try-in service.*

### Step 3- Restoration Material & Design (Required to select one of each)

**Material:**  Milled PMMA  Milled Acetal  Other \_\_\_\_\_

**Restorative Space for Design:**  FP1 (Crown & Bridge no pink)  FP2 (Crown & Bridge w/ slight pink)  FP3 (Traditional Hybrid w/ pink)

### Step 4 - Restorative Appointments

#### Pre-Surgical

**Records to Capture:**

- Upper & Lower Study Cast (REQUIRED)
- Centric Relation Bite (REQUIRED)
- Horizontal Reference (Kois plate or stick bite)
- Photography Series
- Shade \_\_\_\_\_ (vita 16 only) (REQUIRED)

Notes: \_\_\_\_\_

#### Surgical

**Records to Capture:**

- Master Implant Impression (REQUIRED)
- Filled Bite Shell (REQUIRED)
- Centric Relation Bite w/ Bite Shell in place (REQUIRED)
- Mush Bite (optional only if bite shell can't be utilized)

**Components Supplied By:**

Parts	QTY	Surgical	Restorative	Lab
Impress. Coping	____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Analog	____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cylinder	____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Screw	____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Implant System: \_\_\_\_\_ (REQUIRED)

Notes: \_\_\_\_\_

**Any incomplete areas marked in blue can result in the delaying of your case or reserving a chairside technician.**

#### Try-in (Optional Appointment)

**Records to Capture:**

- Indicate esthetic changes below (REQUIRED)
- New Bite (REQUIRED)
- Photograph patient and email pictures

**Email Photos: info@PetersonDentalLab.com**

Notes: \_\_\_\_\_

Dr. Signature \_\_\_\_\_ License # \_\_\_\_\_  
 (REQUIRED) (REQUIRED)

The person signing this work authorization accepts sole responsibility for payment and agrees to pay all collection costs including attorney's fees. A 2% late charge will be added to all balances due over 30 days. NOTE: Retain one sheet for your records and return the other sheet(s) with work to be completed. Please use black or blue when completing this form.