

Contact Information

Dr Name: _____
 Pt. Name: _____
 Account #: _____
 Email: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Gender: Male Female

Logistics

Today's Date: ____/____/____
Return Date: ____/____/____

5 Days in Lab = SR Crown (Tibase) or Try-In Device
10 Days in Lab = ScrewMentable or Cemet Retained
Do not Count transit to and from lab

Restorative Options

Select Abutment:

- Screw-Retained (with Tibase) *(Default)*
- Screw-Retained (with Custom Abutment)
 - Anodize Gold
- Cement-Retained (with Custom Abutment)
 - Anodize Gold

Select Crown:

- ZIR PFZ *(default anterior)*
- ZIR PFZ Bella *(default single center)*
- ZIR FCZ ML *(default posterior)*
- PFM

Completion Level

- Go to Finish
- Try-In Device

Shade

If no "Abutment Type" selected:

1. We will produce it as **Screw-Retained with Tibase**.
2. If this is not ideal, then we will proceed with a **Screw-Retained with Custom Abutment**.
3. If this is not ideal, then we will proceed with a **Cement-Retained with Custom Abutment**. If we change from screw-retained to cement-retained the practice will be call for approval.

Implant Information

Tooth #	Manufacturer	Connection	Platform Diameter

Digital Submission

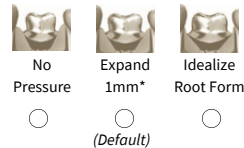
Scan Body Type:

- Dess Atlantis IO ELOS Medentika Straumann Mono
- Neodent NT Trading Preat TruAbutment Straumann Metal Other _____

File Submission

- IOS Portal Email w/ file Email w/ File Sharing Link Other _____

Emergence Profile



Margin Placement



Crown Specifications

- | | |
|--|--|
| Adjacent Contacts | Occlusal Clearance |
| <input type="radio"/> Pin Point | <input type="radio"/> Just out of occlusion |
| <input type="radio"/> Light <i>(Default)</i> | <input type="radio"/> Light <i>(Default)</i> |
| <input type="radio"/> Firm | <input type="radio"/> Other: _____ |
| <input type="radio"/> Tight | |

Main: (561) 272-6662

Email Photos: Info@petersondentallab.com

Send Design Approval

Call Me Customer Experience

Call Me Technical Support

Yes

Yes

Yes

Dr. Signature _____ License # _____

The persons signing this work authorization accepts sole responsibility for payment and agrees to pay all collection costs including attorney's fees. If restorative dentist is covering certain cost please note on RX above. 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 ink when completing this form.