PETERSON
DENTAL LABORATORY

Implant Fixed RX

Contact Information

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

Logistics

Todays 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

No Pressure ○ | Expand 1mm* ○ *(Default)* | Idealize Root Form ○

Margin Placement

360° at Tissue Height ○ | Facial 180° at 1.5mm* Palatal 180° at .5mm ○ *(Default)* | 360° 1.5mm Below Tissue Height ○

Crown Specifications

Adjacent Contacts
- ○ Pin Point
- ○ Light *(Default)*
- ○ Firm
- ○ Tight

Occlusal Clearance
- ○ Just out of occlusion
- ○ Light *(Default)*
- ○ Other: _____

Main: (561) 272-6662
Email Photos: Info@petersondentallab.com

Send Design Approval ○ Yes
Call Me Customer Experience ○ Yes
Call Me Technical Support ○ 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.