

Doctor
Docteur

Address
Adresse



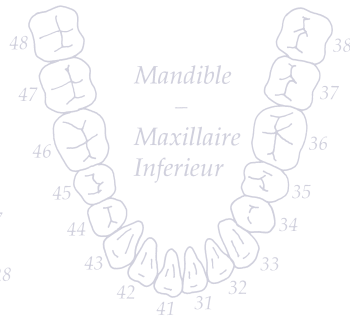
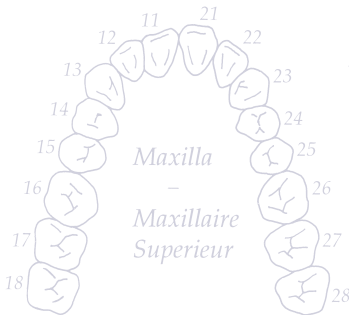
Date

Date Required D/J / M/M / Y/A
Date requise / / /

Appt time AM
R.V. PM

Patient

Zirconia Layered / En couche <input type="checkbox"/> Full contour } Shaw Zir <input type="checkbox"/> Plain contact } Shaw ST <input type="checkbox"/>		E.max Monolithic / Monolitique <input type="checkbox"/> Layered / Plein contact <input type="checkbox"/>		PFM metal choice NP <input type="checkbox"/> SP <input type="checkbox"/> Choix céramométal P <input type="checkbox"/>		M F Age 					
Shade Teinte 		Pontic Design Dessin de Pontiques 		Semi hygienic Semi Hygienique 		Ovate / Ovale 		Ridgelap 		Hygienic / Hygienique 	
Mould Moule 		Contacts Embrasures 		1 Broad / Large 		2 Normal / Normale 		Occlusal Relief Espace Occlusal Yes / Oui <input type="checkbox"/> No / Non <input type="checkbox"/>			
Implant: Cement Retained / Cimenté <input type="checkbox"/> Screw Retained / Visse <input type="checkbox"/>		Facial Margin / Épaulement Buccal:		Metal / Métal <input type="checkbox"/> Porcelain to Metal / Porcelaine Métal <input type="checkbox"/> Butt / Épaulement en Porcelaine <input type="checkbox"/>							



Signature



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