

Doctor _____

Address _____



Date _____

Date Required _____

D / M / Y

Appt time AM
PM

Patient _____

M F Age _____

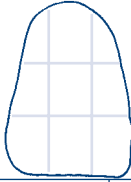
E.max
Monolithic
Layered

Zirconia
Layered
Full contour

PFM metal choice
NP
SP
P



Shade _____



Pontic Design
Semi hygienic
Ovate
Ridgelap
Hygienic

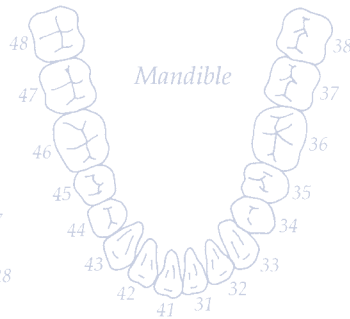
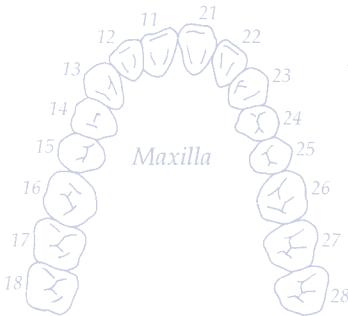
Contacts
1 Broad
2 Normal
Occlusal Relief
Yes
No

Mould _____

Implant: Cement Retained
Screw Retained

Facial Margin: Metal
Porcelain to Metal
Butt

Full Denture
Partial Chrome
Partial Acrylic



Signature _____



Centre of Excellence

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