

Doctor \_\_\_\_\_

Address \_\_\_\_\_



Date \_\_\_\_\_

Date Required \_\_\_\_\_

D / M / Y

Appt time AM   
PM

Patient \_\_\_\_\_

M F Age \_\_\_\_\_

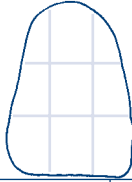
E.max   
Monolithic   
Layered

Zirconia   
Layered   
Full contour

PFM metal choice  
NP   
SP   
P



Shade \_\_\_\_\_



Pontic Design  
Semi hygienic   
Ovate   
Ridgelaip   
Hygienic

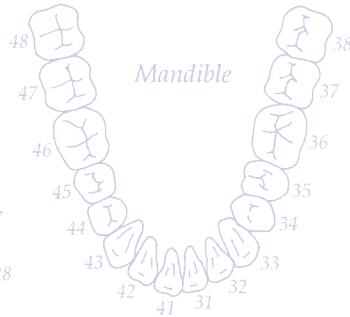
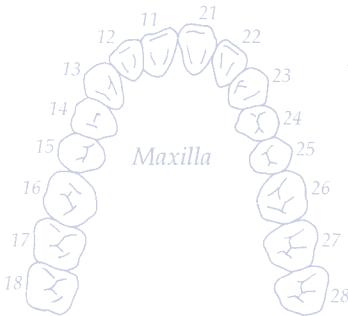
Mould \_\_\_\_\_

Contacts  
1 Broad   
2 Normal   
Occlusal Relief  
Yes   
No

Implant: Cement Retained   
Screw Retained

Facial Margin: Metal   
Porcelain to Metal   
Butt

Full Denture   
Partial Chrome   
Partial Acrylic



Signature \_\_\_\_\_



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