



World Dental Laboratory Co., Ltd.

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18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

PFM: (Crown, Br, Post - crown, Maryland Br) [Ni-Cr* Co-Cr Pure Titanium]
FM: (Crown, Br, Inlay / Onlay, Post - Core, Post - crown, Maryland Br) [Semi-Precious High-precious]
Implant: (Cement-retained Screw-retained)
Customized Abutments: (Pure Titanium Zirconia Abutment-Crown)
Full Ceramic: (Crown, Bridge, Inlay / Onlay, Veneer, Post - Core, Maryland Bridge)
 e.Max Cercon Lava In-Ceram Zenostar Upcera Ceramage Composite]
Precision Attachments: _____ **Telescope Crowns:** _____

Notes:

Clinic/Hospital: _____ Case Number: _____

Dr. Name: _____ (Please indicate exactly and clearly.)
Return Date: / / Normal Urgent Case (Extra Charge)
Pt. Name: _____ Male Female Age: _____ Nickel Allergy: Yes No

Enclosed Contents: Tray Stone Model Bite Rim Photos Cr./Br. Acrylic Teeth

Occlusal Stain: <input type="checkbox"/> None <input type="checkbox"/> Light* <input type="checkbox"/> Medium <input type="checkbox"/> Dark		Incisal Translucency: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Medium* <input type="checkbox"/> Dark
	Metal Design: Lingual: _____ mm Buccal: _____ mm	Porcelain Shoulder: <input type="checkbox"/> None* <input type="checkbox"/> Buccal <input type="checkbox"/> 180° <input type="checkbox"/> 360°
Embrasure: <input type="checkbox"/> Normal* <input type="checkbox"/> Closed	Proximal Contact: <input type="checkbox"/> Normal* <input type="checkbox"/> Extended	<input type="checkbox"/> Light <input type="checkbox"/> Normal* <input type="checkbox"/> Heavy
Occlusal Contact: <input type="checkbox"/> Heavy <input type="checkbox"/> Light* <input type="checkbox"/> Open	Pontic Design: <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

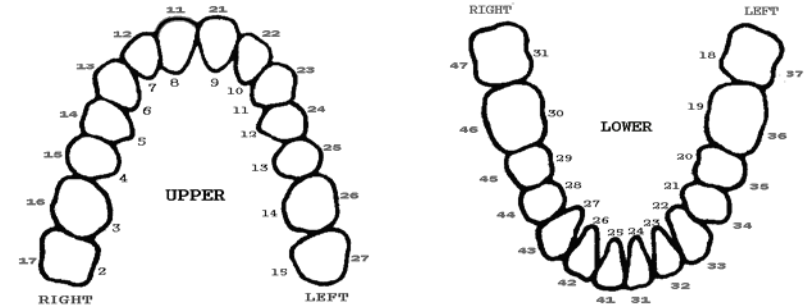
If occlusal clearance is insufficient, allow lab to:
 Adjust Opposing Trim Die Make Metal Points Make 3/4 Metal Occlusion Contact Dr.

REMOVABLE PROSTHETICS

U/ L Special Tray U/ L Bite Rim U/ L Bleaching Tray
 U/ L Full/Partial Acrylic Denture [Set-up teeth + Finish] U/ L _____
 U/ L Valplast Flexible Denture [Set-up teeth + Finish]
 U/ L Metal Based Denture [Framework + Set-up + Finish]
(Co-Cr* Vitallium Pure Titanium BPD)

Notes:

ORTHODONTICS



Doctor's Signature: _____ (NOTE: * = Standard Protocol Unless Specified Otherwise.)