







Due Date	Case #	Patient	
LAB USE ONLY			
Doctor's Information			
Name _____		Address _____	
City and State _____		Telephone _____	
Patient Information			
Name _____		O Male O Female Age _____	
Cement Date: () am / pm O Mon O Tue O Wed O Thur O Fri O Sat			
Case Design Please Allow Ten (10) Working Days			
Tooth Numbers to be Restored _____		Basic Shade _____ Stump Shade _____	
			
<input type="checkbox"/> BruxZir® <input type="checkbox"/> E Max Zimax® <input type="checkbox"/> E Max Press <input type="checkbox"/> E Max Press/Layered <input type="checkbox"/> Feldspathic Veneers <input type="checkbox"/> Diagnostic Wax Up		Pontic Design <input type="checkbox"/> Modified Ridgecap <input type="checkbox"/> Ovate <input type="checkbox"/> Sanitary <input type="checkbox"/> Soft Tissue Model	
Anterior Characteristics			
Incisal Translucency _____ Show Mammalons _____ Surface Texture _____ Cervical Blending _____ Occlusal Stain _____ Hypocalcification _____		<input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> None	
 			
Work Authorization			
Doctors Signature Authorizing the Specified Work _____			
Date Sent _____		DDS License # _____	
		Please send: <input type="checkbox"/> RX Forms <input type="checkbox"/> Boxes <input type="checkbox"/> Airbills	

Ideal Smiles 1015 Sage Drive, Pleasant Grove UT 801-427-9230 Office 801-604-5110 Mobile IdealSmilesForYou@gmail.com

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