DAMORE DENTAL LAB

Lab prescription

01 / Crown, bridge & implant

888-368-0640
lab@damoredentallab.com
439 Spring Street, Suite 1 | Houtzdale, PA 16651
Mon-Fri 8:00 AM-5:00 PM | damoredentallab.com

Office name | **Doctor name** | **Date sent** | **Return by (in office)**

Patient name / ID | **Sex** | **Age** | **Office phone** | **Office email**

Shipping address | **City** | **State** | **ZIP code**

RESTORATION / MATERIAL

Porcelain fused to metal (PFM)

☐ Non-precious ☐ Semi-precious ☐ High noble

All-ceramic

☐ e.max crown ☐ Zirconia
☐ Inlay / onlay ☐ Veneer

Full cast

☐ Non-precious ☐ Semi (silver) ☐ High noble

Implant crown - attachments excluded

☐ Non-precious ☐ Semi-precious
☐ High noble ☐ All porcelain

Implant system / platform / component details

Additional services

☐ Porcelain butt margin ☐ Post & core
☐ Rest seat ☐ Maryland bridge

Other service / material instructions

TOOTH SELECTION / PERMANENT NUMBERING

Patient right — Patient left

Upper ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16

Lower ☐ 32 ☐ 31 ☐ 30 ☐ 29 ☐ 28 ☐ 27 ☐ 26 ☐ 25 ☐ 24 ☐ 23 ☐ 22 ☐ 21 ☐ 20 ☐ 19 ☐ 18 ☐ 17

Shade | **Shade system / type** | **Tooth shade / bridge & pontic details**

Occlusal staining ☐ None ☐ Light ☐ Medium ☐ Dark

CONTACT / PONTIC DESIGN

Contacts

☐ Normal ☐ Heavy & broad ☐ Point

Pontic

☐ Modified ridge (standard) ☐ No contact
☐ Point contact ☐ No ridge

Anterior design ☐ 3/4 metal ☐ 1/4 metal
Lingual coverage

MARGIN / OCCLUSION

☐ Standard ☐ Full porcelain coverage

Metal occlusal:

☐ Excl. buccal cusp ☐ Incl. buccal cusp

Occlusion ☐ In ☐ Slightly out ☐ Out

If bite is tight

☐ Adjust opposing ☐ Spot prep
☐ Reduction coping ☐ Metal pad ☐ Call me

Special instructions / design notes

Doctor signature (sign after printing or use a PDF signing tool) | **License number** | **Date authorized**

DAMORE DENTAL LAB

Lab prescription

02 / Dentures, partials & appliances

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Office name _____ **Doctor name** _____ **Date sent** _____ **Return by (in office)** _____

Patient name / ID _____ **Sex** _____ **Age** _____ **Office phone** _____ **Office email** _____

Shipping address _____ **City** _____ **State** _____ **ZIP code** _____

DENTURES / PARTIALS

- ☐ Standard denture
- ☐ Premium denture
- ☐ Acrylic partial
- ☐ Flipper
- ☐ Metal-based partial
- ☐ Flexible partial
- ☐ Vitallium metal partial
- ☐ Premium partial
- ☐ Metal partial / Valplast clasp
- ☐ Valplast
- ☐ Metal framework
- ☐ Vitallium metal framework

Arch ☐ Upper ☐ Lower

Stage ☐ Wax rim ☐ Set up ☐ Try-in ☐ Finish

Clasp ☐ Wire ☐ Ball

Other clasp / design _____

Shade _____ **Mould** _____ **Tooth numbers** _____

Papillameter rest (mm) _____ **Smile (mm)** _____

Alameter (mm) _____ **Overbite (mm)** _____ **Overjet (mm)** _____

☐ Name in denture / partial **Name to print** _____

APPLIANCES / ADDITIONAL SERVICES

- ☐ Hard night guard
- ☐ Soft night guard
- ☐ Bilateral space maintainer
- ☐ Unilateral space maintainer
- ☐ Bleaching tray
- ☐ Retainer (per arch)
- ☐ Custom tray
- ☐ Duplicate model
- ☐ Process denture
- ☐ Process partial
- ☐ Repair
- ☐ Add tooth / teeth

Appliance arch ☐ Upper ☐ Lower

Other service / Valplast partial design / repair details _____

Special instructions / tooth positions / design sketch

Doctor signature (sign after printing or use a PDF signing tool) _____ **License number** _____ **Date authorized** _____

Use the page for your case; retain a copy for your records.