

**1** Office Name \_\_\_\_\_  
 Patient \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
 Doctor Name \_\_\_\_\_ Date Sent \_\_\_\_\_ Due Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

**Damore Dental Lab**  
**439 Spring Street** Phone: **814-497-1140**  
**Suite 1** 888-368-0640  
**Houtzdale, PA 16651** Fax: **814-378-7262**

**2 SERVICES**

**Crown & Bridge**

**Porcelain to Metal**

\_\_\_ Non-precious  
 \_\_\_ Semi-precious  
 \_\_\_ High Noble  
 \_\_\_ Captek

**Full Cast**

\_\_\_ Non-precious  
 \_\_\_ Semi-precious (Silver)  
 \_\_\_ High Noble (Yellow)

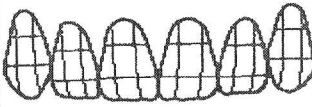
**Metal Free**

\_\_\_ Empress II Crown \_\_\_ Empress II Veneer  
 \_\_\_ Empress II Inlay \_\_\_ Empress II Onlay  
 \_\_\_ IPS E.max \_\_\_ Wol-ceram  
 \_\_\_ Zirconia \_\_\_ Composite

**Additional Lab Services**

\_\_\_ Porcelain Butt Margin  
 \_\_\_ Post & Core  
 \_\_\_ Occlusal Rest Seat  
 \_\_\_ Survey Crown  
 \_\_\_ Maryland Bridge  
 \_\_\_ Cantilever  
 \_\_\_ Space Maintainer  
 \_\_\_ Implant Crown  
 \_\_\_ Implant Abutment  
 Included: Y \_\_\_\_\_ N \_\_\_\_\_  
 \_\_\_ Occlusal Guard: \_\_\_ Upper \_\_\_ Lower

**3 CERAMIC SHADE INSTRUCTIONS**




Shade \_\_\_\_\_  
 Shade Type \_\_\_\_\_

**OCCLUSAL STAINING**

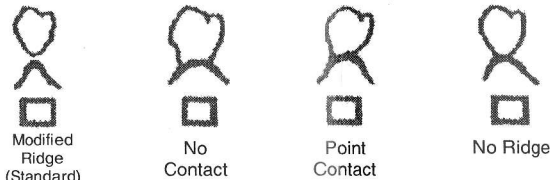
None  
 Light  
 Medium  
 Dark

**4 CONTACTS**



Normal Heavy & Broad Point


**5 PONTIC DESIGN**



Modified Ridge (Standard) No Contact Point Contact No Ridge


**6 BUCCAL MARGIN**

Standard Full Porcelain Coverage Metal Occlusal



Excluding Buccal Cusp Including Buccal Cusp

**7 ANTERIOR DESIGN**



3/4 METAL LINGUAL 1/4 METAL LINGUAL

**8 TOOTH NUMBER(S)** \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

**9 OCCLUSION**

\_\_\_ In Occlusion \_\_\_ Slight Out of Occlusion \_\_\_ Out of Occlusion

If Bite Is Tight,

\_\_\_ Adjust Opposing \_\_\_ Place Metal Pad  
 \_\_\_ Spot Prep \_\_\_ Call Me  
 \_\_\_ Reduction Coping

**2 SERVICES**

**Dentures & Partials**

Shade \_\_\_\_\_ Mould \_\_\_\_\_

Papillameter Rest \_\_\_\_\_ mm Smile \_\_\_\_\_ mm

Alameter \_\_\_\_\_ mm

Desired Overbite \_\_\_\_\_ mm Desired Overjet \_\_\_\_\_ mm

**Acrylic Partial:** \_\_\_ Upper; \_\_\_ Lower; \_\_\_ Try In; \_\_\_ Finish  
 \_\_\_ Wire Clasp; \_\_\_ Ball Clasp; \_\_\_ Flipper

**Metal Based Partial:** \_\_\_ Upper; \_\_\_ Lower; \_\_\_ Metal Framework

**Valplast Partial:** \_\_\_ Upper; \_\_\_ Lower;  
 \_\_\_ Flipper-Ant.; \_\_\_ Nesbit-Post.

**Standard Denture** \_\_\_\_\_ **Premium Denture** \_\_\_\_\_

\_\_\_ Upper; \_\_\_ Lower; \_\_\_ Wax Rim; \_\_\_ Set Up;  
 \_\_\_ Finish; \_\_\_ Other: \_\_\_\_\_

\_\_\_ Name in Denture; Print Name \_\_\_\_\_

**10 SPECIAL INSTRUCTIONS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dr. Signature \_\_\_\_\_

License No. \_\_\_\_\_