

ADVANCED COSMETIC PRESCRIPTION

Dr. _____ Date: _____

Address: _____


Patient: _____

Sex: M / F _____ Age: _____

Date required: _____


Tooth #'s to be restored: _____

Cervical _____ **SHADE** _____
Body _____
Incisal _____ Stump _____



OCCL. STAIN

None Yellow
 Light Orange
 Medium Brown



PONTIC DESIGN

1. HARMONY <input type="checkbox"/>	2. CONE <input type="checkbox"/>	3. HYGENIC <input type="checkbox"/>	4. RIDGELAP <input type="checkbox"/>
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Surface Anatomy

Smooth Medium Heavy

Incisal Translucency

Heavy Medium Light None

Desired length of centrals _____ mm

Smile catalog selection _____

Study model required for all cases:
 copy study model copy wax-up make ideal

Call Me
Case/Instructions: _____

If insufficient room reduce & mark please call

Dr's Signature: _____

