



Lab Sheet

Doctor:	
Patient's Name:	
Clinic:	
Phone:	
Appointment Time:	

RESTORATION

- |                                 |   |  |
|---------------------------------|---|--|
| <input type="checkbox"/> Crown  | <input type="checkbox"/> Implant                  | <input type="checkbox"/> Post and Core |
| <input type="checkbox"/> Bridge | <input type="checkbox"/> Bonded (Maryland) Bridge |  |
| <input type="checkbox"/> Veneer | <input type="checkbox"/> Inlay / Onlay            |  |

MATERIAL

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> IPS e.max Monolithic      | <input type="checkbox"/> Porcelain Fused To Metal (PFM) | } | <input type="checkbox"/> Precious     |
| <input type="checkbox"/> IPS e.max Laminated       | <input type="checkbox"/> Full Metal                     |   | <input type="checkbox"/> Non-Precious |
| <input type="checkbox"/> Monolithic Zirconia       |   |   |                                       |
| <input type="checkbox"/> Zirconia Buccal Laminated |   |   |                                       |
| <input type="checkbox"/> Zirconia Laminated        |   |   |                                       |

IMPLANT TYPE

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Direct To Fixture | <input type="checkbox"/> Cement Retained | <input type="checkbox"/> Cross Pin |
|--|--|------------------------------------|

SHADE



INSTRUCTIONS

Please Circle Tooth Numbers To Be Restored  
 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