BC DIGITAL DENTAL STUDIO

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Vancouver, BC, V5Z 4J7 **P:** 778-200-6059 • **E:** info@bcdds.ca

DOCTOR'S NAME	RECEIVED BY LAB
PATIENT'S NAME	☐ Male ☐ Female Age____

DATE REQUIRED:	MONTH	DAY	TIME

ENCLOSED: ☐ Impressions ☐ Models ☐ Bite ☐ Photos ☐ Other_____

SENT: ☐ Intraoral scan ☐ Photos ☐ CT scan

INSTRUCTIONS:

RESTORATION

☐ IPS e.max ☐ Full Contour Zirconia ☐ Layered Zirconia

REMOVABLE

☐ Full denture ☐ Nightguard ☐ Other

IMPLANT

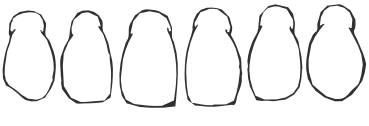
☐ Crown/Bridge ☐ Bar ☐ Overdenture ☐ Fixed arch ☐ Surgical guide

OCCLUSION

☐ Centric contact only ☐ No contact (shimstock relief)

IF INSUFFICIENT ROOM

☐ Reduce and Mark Preparation ☐ Please Call ☐ Reduce and Mark Opposing
☐ Reducing Coping



Shade Desired _____

Prep Shade _____

PLEASE SEND A STUDY MODEL FOR ALL WORK INVOLVING ANTERIOR TEETH