

PROWEST

International Dental Services

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Dr. _____

Date Shipped: _____

Date Required: _____ Time: _____

Patients Name: _____
(PLEASE PRINT)

Rx: _____

Please indicate case requirements below

A. METAL	<input type="radio"/> GOLD	<input type="radio"/> SEMI-PREC	<input type="radio"/> NON-PREC
B. OCCLUSION	<input type="radio"/> METAL	<input type="radio"/> PORCELAIN	
C. CENTRIC CONTACT	<input type="radio"/> FOIL RELIEF	<input type="radio"/> POSITIVE CONTACT	<input type="radio"/> CUSP FOSSA
D. LATERAL EXCURSION	<input type="radio"/> CUSPID GUIDANCE	<input type="radio"/> GROUP FUNCTION	
E. MARGIN ADAPTION	<input type="radio"/> EXACTLY TO FINISH LINE	<input type="radio"/> SLIGHT OVEREXTENSION	
F. LABIAL MARGIN	<input type="radio"/> FINE METAL COLLAR	<input type="radio"/> PORCELAIN TO MARGIN	<input type="radio"/> PORCELAIN BUTT MARGIN

G. PONTIC DESIGN	<input type="radio"/> HARMONY	<input type="radio"/> CONE	<input type="radio"/> HYGENIC	<input type="radio"/> RIDGELAP
H. CONTACTS	<input type="radio"/> BROAD	<input type="radio"/> NORMAL	<input type="radio"/> POINT	
I. SHADE	_____			

Doctor's Signature: _____