

DIAGNOSTIC WAX UP PRESCRIPTION

Date: _____

Doctor Name: _____ Patient Name: _____

Doctor Address: _____ Phone: _____

Enclosed is the following information:

1. Upper and lower pre-op models or Poly-Vinyl Siloxane impressions enclosed
2. Photographs
 - a. Full face smiling
 - b. Anterior smile
 - c. Anterior retracted
3. Stick bite and photo
4. Requested length approximation:
 - a. Central _____
 - b. Lateral _____
 - c. Canine _____
5. Anticipated tissue changes:
 - a. Tooth number and amount _____
 - b. Tooth number and amount _____
6. Buccal corridor, enhance upper arch width by _____ mm to the facial on #'s _____.
7. Midline changes
 - a. Move upper midline 0mm / 0.5mm / 1.0mm to the patient's Left / Right
8. Desired Restoration CEJ to CEJ
 - a. Maintain existing CO
 - b. Consider opening later: _____ mm
9. Teeth involved in **crown** wax-up #'s _____
10. Teeth involved in **veneer** wax-up #'s _____

Note: _____

Doctor's Signature _____

Doctor's License no. _____