

LAB NAME _____

DR. NAME _____

FULL ADDRESS _____

GROUP / PRACTICE NAME _____

EMAIL _____ PHONE _____

PATIENT INFO FIRST NAME _____ FEMALE
 LAST NAME _____ MALE
 AGE _____

DUE DATE _____ **TODAY'S DATE** _____
Standard working time if no date is provided.

INTERFACE

COMPONENT SELECTION
 OEM Universal*

RESTORATION TYPE
 Cement-retained
 Screw-retained
IF SCREW HOLE IS MALPOSITIONED
 Please call
 Convert to cement-retained
 Use angled screw components
 Angled screw driver needed*
*Additional Fee May Apply

RESTORATION MATERIAL
 Full Contour Zirconia*
 Aesthetic Zirconia
 Layered Zirconia
 Lithium Disilicate LAYERED
 PFM **METAL TYPE** _____
 PMMA Provisional
 Other _____

ABUTMENT MATERIAL
 Titanium* Zirconia
 Gold Anodized Titanium

SURGICAL GUIDE

DESIRED DEFINITIVE RESTORATION
 Single Unit All-on-X
 Bridge Locator®
 Conus

PROVISIONALIZATION
 Essix Retainer
 Temporary Partial
 Immediate PMMA*
 Other _____

CBCT UPLOAD
 Disc Enclosed
 File Upload

METHOD _____

SURGICAL GUIDE TYPE
 Fully Guided Pilot Guide
 Guided Prosthetics®

BEST EMAIL FOR SCREEN-SHARE CASE APPROVAL _____

FULL ARCH IMPLANT SUPPORTED DEFINITIVE RESTORATION

SERVICE LEVEL
 Custom Tray
 Setup/Try-in
 Bite Block
 Reset
 Implant Verification Jig
 Framework Try-in
 Definitive Prosthesis

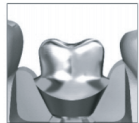
PATIENT INFORMATION
 Papillameter _____
 Alameter _____
 Tooth Mold _____
 Shade _____


PRE-SURGERY
 Guided Prosthetics
 Immediate Temporary Denture Scanning application with radiopaque teeth
 Clear Duplicate Denture with slot and 15mm border for surgical guide


GINGIVAL SHADE
 Standard
 Medium
 Dark

DEFINITIVE RESTORATION TYPE
 Full Arch Zirconia
 Crystal Ultra®
 Hybrid
 Copymill/Individual Crowns
 Conus Bundle
 Locator Denture Bundle

EMERGENCE PROFILE

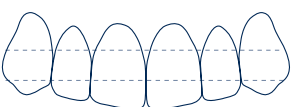
Follow tissue (no expansion) 

Contour design (expand tissue by 0.5mm) 

Anatomical (fully expand tissue) 

TOOTH #	MANUFACTURER	CONNECTION TYPE	PLATFORM SIZE	MARGIN DEPTH

SHADE _____

DESIRED 

ITEMS REQUIRED:
 ■ CT SCAN in multi slice .dicom format
 ■ Physical impression or digital impression in .stl format. Please zip files before sending.
***FOR SENDING YOUR GUIDED PROSTHETICS CASE:**
nsequence.com/ct-guided-prosthetics-order

SPECIAL INSTRUCTIONS _____


DIGITAL SCAN SENT

ENCLOSED WITH CASE

MODEL BITE PHOTOS TEETH OTHER _____
 SHADE TAB IMPRESSIONS METAL TRAYS ARTICULATOR _____

DR. SIGNATURE _____

DR. LICENSE # _____ **EXPIRES** _____

 **FOR LAB CONTACT INFO** nationaldentex.com/labs

NDX WARRANTY nationaldentex.com/warranty

REQUEST SUPPLIES
 _____ RXS
 _____ BOXES
 _____ LABELS
 OTHER _____

FOR LAB USE ONLY

MKT00219_RevC

*Default option if no option is selected.