NDX NATIONAL DENTEX LABS

Implant Rx Form

Laboratory Procedure Authorization

***ALL YELLOW HIGHLIGHTED AREAS ARE REQUIRED**. An incomplete form will result in case delays until proper data can be collected.*

LAB NAME			
DR. NAME			
FULL ADDRESS			
GROUP / PRACTICE NAME			
EMAIL		PHONE	
PATIENT INFO	FIRST NAME		☐ FEMALE ☐ MALE
	LAST NAME		AGE _____
DUE DATE Standard working time if no date is provided.		TODAY'S DATE	

INTERFACE

COMPONENT SELECTION
☐ OEM ☐ Universal*

ABUTMENT MATERIAL
☐ Titanium* ☐ Zirconia
☐ Gold Anodized Titanium

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 _____

SURGICAL GUIDE

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

SURGICAL GUIDE TYPE
☐ Fully Guided ☐ Pilot Guide
☐ Guided Prosthetics®

PROVISIONALIZATION
☐ Essix Retainer
☐ Temporary Partial
☐ Immediate PMMA*
☐ Other
_____

CBCT UPLOAD
☐ Disc Enclosed
☐ File Upload

METHOD
_____

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 _____

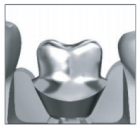
PRE-SURGERY
☐ Guided Prosthetics
☐ Immediate Temporary Denture Scanning application with radiopaque teeth
☐ Clear Duplicate Denture with slot and 15mm border for surgical guide

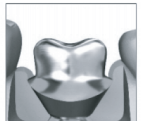
GINGIVAL SHADE
☐ Standard
☐ Medium
☐ Dark

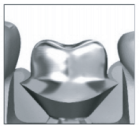
DEFINITIVE RESTORATION TYPE
☐ Full Arch Zirconia
☐ Crystal Ultra®
☐ Hybrid
☐ Copymill/Individual Crowns
☐ Conus Bundle
☐ Locator Denture Bundle

*Default option if no option is selected.

EMERGENCE PROFILE


☐ Follow tissue (no expansion)

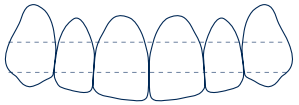

☐ Contour design (expand tissue by 0.5mm)


☐ 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			**REQUEST SUPPLIES**
DR. LICENSE #		**EXPIRES**	☐ RXS ☐ BOXES ☐ LABELS OTHER _____

FOR LAB CONTACT INFO
nationaldentex.com/labs

NDX WARRANTY
nationaldentex.com/warranty

FOR LAB USE ONLY