



1/F NO 41 MA WAN NEW VILLAGE PA MEI
 ROADTUNG CHUNG LANTAU ISLAND HONG KONG
 Tel : +86-13035843579
 Email : info@identure.cn

Dr. _____
 Address _____
 City, Zip _____ Phone _____
 Patient _____ M _____ F Age _____

Date
Return Date & Time

REMOVABLE	
<input type="checkbox"/> Custom Tray <input type="checkbox"/> Occlusal Rim <input type="checkbox"/> Teeth Set Up <input type="checkbox"/> Acrylic Process <input type="checkbox"/> Valplast <input type="checkbox"/> Overdenture <input type="checkbox"/> Metal Framework <input type="checkbox"/> Cocr <input type="checkbox"/> Vitallium2000 <input type="checkbox"/> Titanium <input type="checkbox"/> Economy Teeth <input type="checkbox"/> Premium Teeth <input type="checkbox"/> Try In <input type="checkbox"/> Finish	
FRAMEWORK DESIGN	OTHERS
<input type="checkbox"/> Lingual Bar <input type="checkbox"/> Lingual Plate <input type="checkbox"/> A-P Strap <input type="checkbox"/> Horse Shoe <input type="checkbox"/> Ackers/Unilateral <input type="checkbox"/> Metal Backing <input type="checkbox"/> Dummy Teeth <input type="checkbox"/> Clear Clasp <input type="checkbox"/> Valplast Clasp <input type="checkbox"/> Tooth Color Clasp <input type="checkbox"/> Shade _____	<input type="checkbox"/> Repair <input type="checkbox"/> Reline <input type="checkbox"/> Rebase <input type="checkbox"/> Add Teeth <input type="checkbox"/> Laser Weld <input type="checkbox"/> Soft Liner <input type="checkbox"/> Band & Loop <input type="checkbox"/> Bleaching Tray <input type="checkbox"/> Study Model <input type="checkbox"/> Hawley Retainer <input type="checkbox"/> Clear Retainer <input type="checkbox"/> Surgical Stent <input type="checkbox"/> Hard Night Guard <input type="checkbox"/> Soft Night Guard <input type="checkbox"/> Hard/Soft Guard

Tooth #'s _____ Shade _____
 Single Solder Bridge

Instructions :

Signature _____ License Number _____

IMPLANT			
<input type="checkbox"/> Custom Abutment <input type="checkbox"/> Titanium <input type="checkbox"/> Zirconia		<input type="checkbox"/> Stock Abutment <input type="checkbox"/> UCLA Abutment	
<input type="checkbox"/> Implant System _____ <input type="checkbox"/> Diameter _____			
ALL CERAMIC		OTHER RESTORATIONS	
<input type="checkbox"/> Full Zirconia <input type="checkbox"/> Layered Zirconia <input type="checkbox"/> Emax Layered <input type="checkbox"/> Emax Monolithic <input type="checkbox"/> Multilayer/Translucent Zirconia		<input type="checkbox"/> Diagnostic Wax Up <input type="checkbox"/> Composite Inlay/Onlay <input type="checkbox"/> Temporary/Provisional/Acrylic teeth <input type="checkbox"/> NP Post & Core <input type="checkbox"/> With OP <input type="checkbox"/> Without OP <input type="checkbox"/> Post and crown separate <input type="checkbox"/> Post and crown one piece	
PFM		FULL CAST	
<input type="checkbox"/> Non-Precious <input type="checkbox"/> High Noble Yellow <input type="checkbox"/> Semi-Precious <input type="checkbox"/> High Noble White		<input type="checkbox"/> Non-Precious Yellow <input type="checkbox"/> High Noble Yellow <input type="checkbox"/> Non-Precious White <input type="checkbox"/> High Noble White	
PONTIC DESIGN		METAL DESIGN	
		<input type="checkbox"/> Lingual Metal Collar <input type="checkbox"/> 180° Porcelain Margin <input type="checkbox"/> 360° Metal Margin <input type="checkbox"/> 360° Porcelain Margin <input type="checkbox"/> 360° No Metal Margin <input type="checkbox"/> Metal Lingual/Occlusion	
STAIN	OCLUSION	CONTACT	EMBRASURE
<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Strong	<input type="checkbox"/> In <input type="checkbox"/> Light <input type="checkbox"/> Out	<input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Strong	<input type="checkbox"/> Open <input type="checkbox"/> Normal <input type="checkbox"/> Closed
INSUFFICIENT CLEARANCE			
<input type="checkbox"/> Metal Occlusion <input type="checkbox"/> Metal Island <input type="checkbox"/> Reduce Opposing		<input type="checkbox"/> Reduce Abutment <input type="checkbox"/> With Coping <input type="checkbox"/> Without Coping <input type="checkbox"/> Call Doctor	