Jesse DENTAL FUSIONS

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FIXED RESTORATIONS

Date _____

Doctor Name* _____

Address* _____

City* _____ State* _____ Zip* _____

Email* _____ Phone* _____

Patient Name* _____

Age* _____ ◯ Male ◯ Female ◯ Non-binary

Return by 5:00 PM on _____

◯ Expedite *(fees apply)* ◯ Call me

Do you need? ◯ Rx Forms ◯ Boxes ◯ Shipping Labels

Please check boxes that apply. *** Required Fields.** If no choice is made (°) JDF standards apply.

TOOTH

◯ Crown
◯ Bridge
◯ Pontic
◯ Inlay/Onlay
◯ Veneer
◯ Implant

MATERIAL

◯ Monolithic Zirconia
◯ Porcelain to Zirconia (PFZ)
◯ e.max Monolithic
◯ e.max Layered
◯ Porcelain to Metal (PFM)
◯ Full Cast

If PFM or Full Cast, color and content must be chosen:
Color: ◯ White ◯ Yellow
Content: ◯ Noble ◯ Hi-Noble ◯ Non-Precious

COPING DESIGN

◯ Collarless
◯ Lingual Collar Only
◯ Porcelain Butt Margin

RETURN

◯ Evaluate/call
◯ Dr. trim dies
◯ Complete with model
◯ Complete w/o model °
◯ IOS scan submitted

IMPLANT DESIGN

Implant Line & Platform* _____

Tissue Blanching	Custom Abutment	Screw Retained	Fixed Full-Arch
◯ Ideal	◯ Titanium	◯ PFZ	◯ Zirconia
◯ No Blanching	◯ Zirconia	◯ PFM	◯ Other
◯ Blanching			

◯ Place screw access hole, but do not cement

FURTHER DESIGN REQUESTS

Please indicate tooth # if applicable.

◯ Metal Occlusal _____
◯ Crown Designed for Partial _____
◯ Other _____

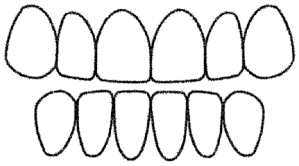
PONTIC DESIGN

CASE SPECS

Shade _____ **Prep Shade** (required for ceramics) _____ **Pink Porcelain Tissue Shade** _____

LAB VISIT

◯ Shade Analysis
◯ Smile Analysis
◯ Custom Stain



TEETH NUMBERS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

◯ **Before and After Pictures**
◯ Email
◯ Print

Occlusal Anatomy	◯ Match Adjacent/Partner °	◯ Ideal		
Occlusal Contact	◯ Light °	◯ Full	◯ Very light	◯ Out of occlusion
Occlusal Stain	◯ Light °	◯ Medium	◯ Dark	◯ None
Translucency	◯ Standard °	◯ Increased	◯ Minimal	◯ As Drawn
Contact Shape	◯ Standard °	◯ Broad	◯ Extra Broad	
Study Model for	◯ Guidance	◯ Exact Duplicate	◯ Incisal Edge Position	
Contour	◯ Match Adj./Partner °	◯ Match Study Model	◯ Ideal	
Occlusion with a close bite	◯ Call °	◯ Trim/Mark Opp.	◯ Trim w/Coping	
Reason for Restoration	◯ Close Spaces	◯ Discoloration	◯ Esthetics	◯ Other
Future Restorations Planned	◯ Diagnostic Wax-Up			

INSTRUCTIONS:

Signature* _____

License #* _____

*The person signing this prescription accepts responsibility for payment and agrees to pay all collection costs including attorney's fees. A 1.5 % (18%/year) inance charge will be added to all balances due over 30 days. Please visit **jessedentalfusions.com** for the most current Rx forms.*