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Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Time Required: \_\_\_\_\_ am / pm

**INSTRUCTIONS:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CR & BR:**  PBM  FMC  ZR Full  ZR Substructure  emax

**ALLOY:**  High Gold  50% Gold  High Pd  Base

**OCCCLUSION:**  Metal  Porcelain  Foil Relief

**EXCURSION:**  Cuspid Guidance  Group Function

**LABIAL MARGIN:**  Metal  Porcelain  Conventional

**IF INSUFFICIENT ROOM:**  Please Call  Reduce and Mark  Preparation  Opposing

**TOOTH SHADE** \_\_\_\_\_ **STUMP SHADE** \_\_\_\_\_

**IMPLANT:** Abutment size \_\_\_\_\_ System \_\_\_\_\_

SCREW retained - 1 piece  CEMENT retained - 2 piece

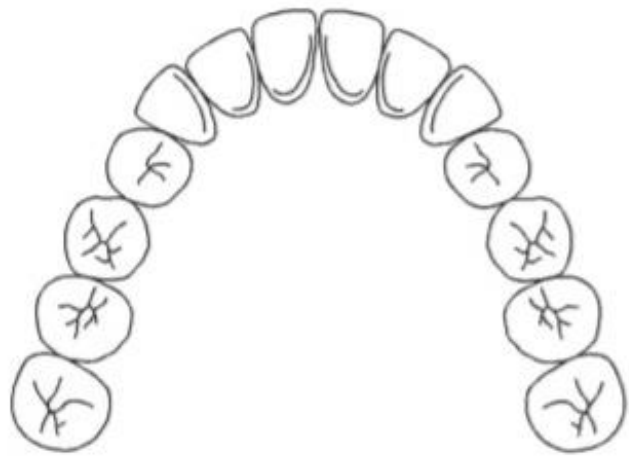
**DENTURE:**  FULL  PARTIAL  ACRYLIC  CAST

REPAIR  Reline  Rebase  LASER Weld  TRY IN  FINISH

**SPLINTS:**  Ultra Comfort  Slim-Line  Hard Acrylic

ORTHODONTICS  SLEEP APPLIANCE OTHER: \_\_\_\_\_

DESIGN CASE HERE



RIGHT

LEFT

