Crosstown Dental Laboratory

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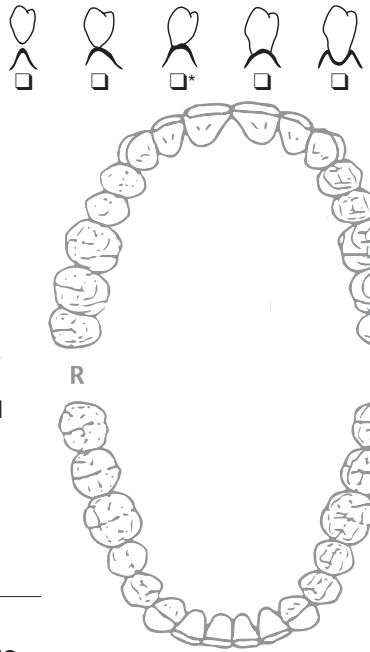
Doctor: _____ Date sent: _____

Address: _____ Date required: _____

Patient: _____ Patient Appt: _____
Last name First name

Doctor Tel #: _____



To be delivered as:
❑Metal Frame Try In
❑Bisque Bake
❑Completed

Type of margin:
❑Porcelain to Metal
❑Butt Joint
❑Metal Band

Type of Restoration:
❑Zirconia
❑Emax ❑Empress
❑PFM
❑Full Metal Crown
❑Other _____

Alloy:
❑Non Precious
❑Semi Precious
❑Gold-White ❑Yellow

Centric Contact
❑Foil Relief
❑Positive
❑CUSP FOSSA

Contacts
❑Broad
❑Normal
❑Point

If Insufficient Room?
❑Please Call
❑Reduction Coping
❑Metal Occlusal/Lingual
❑Reduce/mark on opposing

Orthodontics
❑Splints ❑Mouthguard _____ ❑Other _____

Denture Removables:
❑Acrylic Partial ❑Cast Partial ❑Full Denture

Details:

Tab Shade: _____ Stump Shade: _____

Implant System: _____

Doctor's Signature: _____ Parts Sent by Doctor: ❑Yes ❑No

Letter from Surgeon: ❑Yes ❑No