
259 North 290 West | Lindon, Utah 84042
OFFICE 801.796.9979 | FAX 801.785.1806
www.PerformanceDL.com

Appointment Date: _____ Time: _____

Dr: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Patient Name: _____ Gender: _____

Teeth to be Replaced or Restored:

Type of Restoration:

Metal Based Restorations:

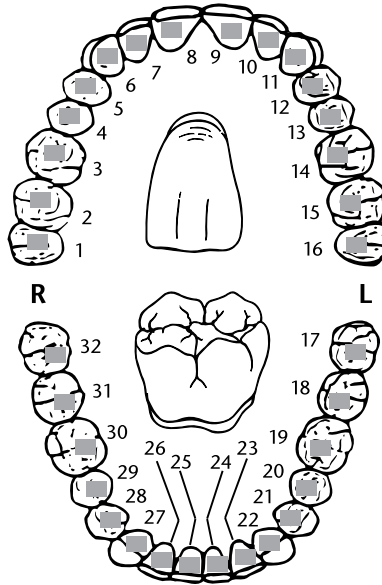
- PFM – Base Metal
- PFM – Semi-Precious
- PFM – High Noble
- Full Gold Crown
- Maryland Bridge

All Ceramic Restorations:

- Feldspathic Veneers
- Empress
- Zirconia
- Emax

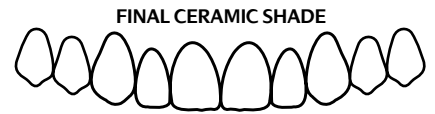
Other Products:

- Implant
 - Brand: _____
 - Other Info: _____
- Diagnostic Wax-up
- Siltech Matrix



If No Occlusal Clearance

| | |
|-----------------------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Call doctor | <input type="checkbox"/> Spot opposing |
| <input type="checkbox"/> Metal occlusion | <input type="checkbox"/> Metal island |
| <input type="checkbox"/> Make reduction coping | |
| <input type="checkbox"/> Make this a permanent note in my master file | |



Indicate Shade Here

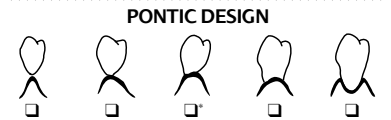


PRESENT TOOTH OR STUMP SHADE

Indicate Shade Here

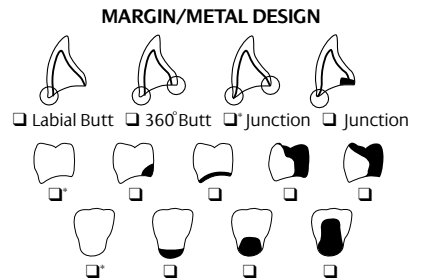
OCCUSAL STAINING

None Light* Medium Dark



RIDGE RELIEF

None Light Moderate Heavy



*Standard unless specified otherwise

Have you included the following?

- Impressions Bite Opposing Shade Pre-Op Model Photos

Please Send:

- Rx's Airbills Boxes

Doctor's Notes _____

Doctor's Signature _____ Call me before proceeding with case

License #: _____ Please evaluate my preps and impressions