111 Cooperative Way, Bldg 2 Ste 200 | Georgetown, TX 78626
512-456-7625 | implanttx@gmail.com

ImplantTx

Crown & Bridge RX

Doctor: _____

Practice: _____

License #: _____

Phone: _____ Address: _____

Note: Turnaround time is based on date the RX is received. Please allow 7 business days (M-F) for complex cases.

Patient Name: _____

RX Date: _____ Due Date: _____

Crown Design

Characterizations _____

Pontic Design _____

Tooth Shade _____

Shade Guide Used (Default: Vita) _____

Stump Shade _____

Pink Tissue Shade _____

If Insufficient Room

__ Trim Opposing*
__ Call To Discuss
__ Metal Occlusal
__ Reduction Coping
__ Metal Island
__ Trim Prep No Coping

Occlusal Contact

__ Light*
__ Open
__ Tight

Interproximal Contact

__ Light*
__ Medium
__ Heavy

***Standard Design If Option Not Selected**

Zirconia / All Ceramic

__ Zirconia Solid
(not recommended for anterior)
__ Zirconia Layered
__ Hi Translucent (Max 3 Unit Bridge)
__ Solid Lingual w/ Porcelain Facial
__ IPS Emax Press (Max 3 Unit Bridge)
__ Lithium Disilicate

Other

__ Composite Resin
__ Temporary Acrylic
__ Temporary With Metal

RX Specific Instructions

Please provide in a photos, study models, diagnostic casts with case email photos to **implanttx@gmail.com.**

Notes: _____

Restoration

__ Crown
__ Bridge
__ No Prep veneer
__ Veneer
__ Inlay / Onlay
__ Implant
__ Diagnostic Wax-up
__ Rest Seats
_____

The person signing this form is an authorized signer and, along with the dental practice, accepts responsibility for payment of all related charges as well as any legal costs, collection, and other fees incurred by Implant TX in the event the account is sent to collections or litigation.

Dentist signature
(Required) _____

Dentist license number
(Required) _____