Denoray Dental Services

Denoray Dental Services
2020 Sylvia Ave NE Unit B
Cedar Rapids, IA 52402
319 393 2655
denorayds@gmail.com

ORDER DATE: ___/___/___
YOUR DUE DATE: ___/___/___

IMPORTANT: Standard restorations will be sent back 5 - 7 working days after cases are received in our facility if uneventful and without any unforeseen delays. Please calculate due dates accordingly for all standard and non-standard restorations. Any questions, please call. Thank you.

Office:_____
Address:_____
City/State/Zip:_____

Phone:_____
Fax:_____
Email:_____

Dentist Name:_____
Patient Name:_____
Case No:_____

Zirconia Restoration:
☐ Full Zirconia
☐ Porcelain Facial (3/4 Zirconia)
☐ Porcelain Layered Zirconia (Coping)

Porcelain Fused to Metal:
☐ Yellow High Noble
☐ White High Noble
☐ White Noble
☐ Base Metal

All Ceramic Restoration:
☐ Emax-C&B
☐ Emax-Inlay
☐ Emax-Onlay
☐ Emax-Veneer

Full Cast Crown/Bridge:
☐ Milled Yellow High Noble
☐ Milled Yellow Noble
☐ White Noble
☐ Base Metal

Porcelain Margin Design:
☐ Facial Only
☐ 360 Degree

Occlusal Contact:
☐ Full Contact   ☐ Light Contact
☐ **No Contact***   ☐ 0.5mm Clearance

Interproximal Contact:
☐ Heavy   ☐ **Medium***
☐ Light

Gingival Embrasure:
☐ Natural   ☐ **Closed***
☐ Open

Occlusal/Cervical Staining:
☐ Dark   ☐ Medium
☐ Light   ☐ **None***

Implant:
Implant Manufacturer:_____
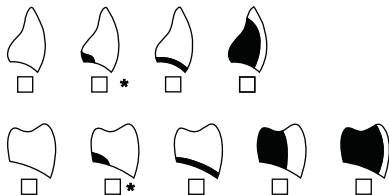Implant Diameter:_____

Type:
☐ Cemented
☐ Screw Retained
  ☐ Titanium
  ☐ Zirconia w/Ti Base

Options:
☐ Screw Retained Hole in Crown
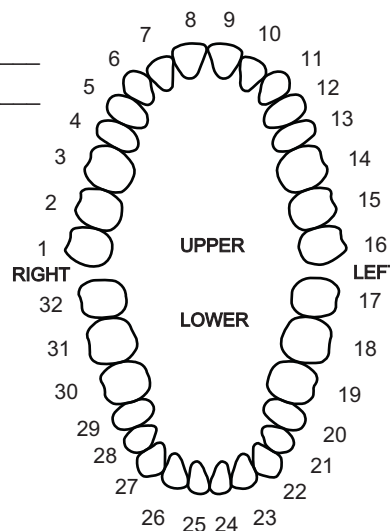☐ Cement Crown to Abutment

Metal Design:

☐   ☐*   ☐   ☐

☐   ☐*   ☐   ☐

Pontic Design:

☐   ☐   ☐*   ☐

Additional Work:
☐ Post+Core Integrated w/ Crown
☐ Post+Core Separated w/ Crown
☐ Maryland Bridge
☐ Fit crown to partial denture
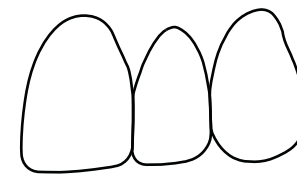

UPPER   LEFT
RIGHT
LOWER

Enclosure/Notes:

FIXED RESTORATION PRESCRIPTION
This is a: ☐ New CASE   ☐ REDO   ☐ REPAIR
Old unit enclosed for redo/repair: ☐ Yes   ☐ No
Old case number for redo/repair:

If No Occlusal Clearance:
☐ Relieve opposing
☐ Metal Occlusal/Lingual
☐ Call Contact Person
☐ Reduce prep w/ reduction coping
☐ Reduce prep w/o reduction coping

Tooth #_____   Shade:_____

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*Standard unless specified otherwise

Authorized Signature for Work:_____   Date:_____