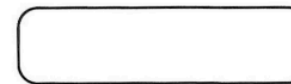


CASE AUTHORIZATION FORM RX

1940 Pavilion Dr, Ste 1, Virginia Beach, Virginia. 23451
Phone: 757-837-6911 - Email: nabil@dubaidentstudio.com



Doctor's Name: _____ Phone: _____

Address: _____

Patient's Name: _____

Age: _____ Male: _____ Female: _____

Date written: _____ Appointment date: _____

Date wanted: _____

PLEASE SEND THE FOLLOWING

- ☐ Prescripton Pads ☐ Boxes ☐ Mailing
Labels

OPPOSING WILL BE RESTORED IN THE NEAR FUTURE?

☐ YES ☐ NO

IF INADEQUATE CLEARANCE

- ☐ Adjust opposing
☐ Make reduction coping ☐ Call me

PLEASE SELECT LEVEL OF SERVICE

☐ MASTER SERVICES ☐ GOOD SERVICES

RESTORATION TYPE

- ☐ Lithium disilicate
☐ Zirconia
☐ Multi-layered monolithic zirconia
☐ Layered zirconia
☐ Feldspathic veneer
☐ PFM
☐ Please Call

IMPLANTS

- ☐ Custom abutment
☐ Cement retained
☐ Screw retained. Lute at the lab, Yes/No
Implant manufacturer and size

*We will contact you if this information is missing

DETAILED INSTRUCTIONS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

DESIRED SHADE _____ OCCLUSAL STAIN YES/NO

STUMP SHADE _____ ☐ very dark or metal post present

PONTIC DESIGN _____ TISSUE ADJUSTMENT MM _____

DIGITAL DIOAGNOSTIC SERVICES

- ☐ DSD
☐ Digital diagnostic wax up
☐ Temp shells PMMA
☐ Injection matrix
☐ Reduction guide
☐ Gingivectomy guide

CUSTOM SHADE SERVICES

☐ YES ☐ NO

Please read minimum requirements for anterior cases on the back.

INCLUDED WITH CASE:

- | | |
|--|--|
| ☐ Upper Impression | ☐ Diagnostic wax-up |
| ☐ Lower Impression | ☐ Old restorations |
| ☐ Opposing model | ☐ Lab analogs, Qty: |
| ☐ Articulator | ☐ Photos/USB |
| ☐ Bite registration | ☐ Pre-op model |
| ☐ Face bow | ☐ Implant parts |
| ☐ Provisional model | ☐ Other |

By signing below, I acknowledge the terms and conditions contained on the reverse of this case authorization form, and such terms are incorporated into this form agreement.

Doctor's Signature _____ License #: _____ Date _____