Saskatoon

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Doctor ______________________ RX Date __________

Address ______________________________________

Phone ______________ Phone (other) ______________

Email ____

Patient Name ____________________ Age _____ Sex _____

Due Date ______________ Time ______________

Rx ____

PLEASE INDICATE CASE REQUIREMENTS BELOW

A)	ZIRCONIA	☐ OPALITE® BASIC	☐ AURUM ESTHETIC ZR MULTI®	
B)	METAL	☐ GOLD	☐ SEMI-PREC. (NOBLE)	☐ NON-PREC.
C)	OCCLUSION	☐ METAL	☐ PORCELAIN	
D)	CENTRIC CONTACT	☐ FOIL RELIEF	☐ POSITIVE CONTACT	☐ CUSP FOSSA
E)	LATERAL EXCURSION	☐ CUSPID GUIDANCE	☐ GROUP FUNCTION	
F)	MARGIN ADAPTATION	☐ EXACTLY TO FINISH LINE	☐ SLIGHT OVEREXTENSION	
G)	LABIAL MARGIN	☐ FINE METAL COLLAR	☐ PORCELAIN TO MARGIN	☐ PORCELAIN BUTT MARGIN

H)	PONTIC DESIGN	1. HARMONY ☐	2. CONE ☐	3. HYGENIC ☐	4. RIDGELAP ☐
I)	CONTACTLESS (EMBRASSURES)	1. BROAD ☐	2. NORMAL ☐	3. POINT ☐	

J) SHADE ______________________________