

DOCTOR _____ (please print)

DATE SENT _____ DATE WANTED _____

CLINIC NAME _____

ADDRESS _____

PATIENT'S NAME _____ TELEPHONE _____

Please send X-ray files and shade information to

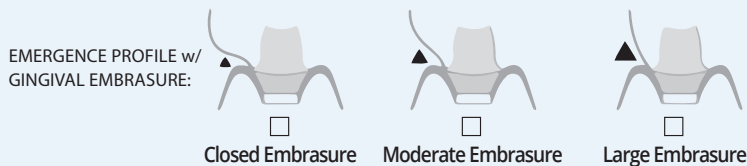
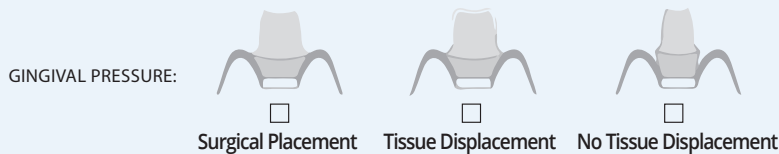
info@skycadtech.com

PLEASE SEND SUPPLIES

- ☐ RX SHEETS
☐ PLASTIC BAGS
☐ SHIPPING WAYBILLS

FIXED PROSTHETICS

- TYPE OF CROWN: ☐ Full Metal ☐ PFM ☐ Post and Core
☐ IPS e.max® ☐ Zirconia (PFZ) ☐ Full Zirconia
☐ Acrylic Temporary ☐ UCLA ☐ ZBLC
- CUSTOM IMPLANT ☐ Titanium ☐ Zirconia
- ABUTMENT: ☐ Brand _____ ☐ Colouring Anodizer
- FULL METAL ALLOY: ☐ White Non-Precious ☐ Yellow Low Gold ☐ Yellow High Gold
- OCCCLUSION: ☐ Metal ☐ Porcelain ☐ Combination
- LABIAL MARGIN: ☐ Metal ☐ Combination ☐ Porcelain Butt
- OCCUSAL CONTACT: ☐ Positive ☐ Foil Relief # of Foils _____



SPECIAL INSTRUCTIONS: _____

DOCTOR'S SIGNATURE: _____

REMOVABLE PROSTHETICS

- TYPE OF DENTURE: ☐ Cast Metal Partial ☐ Titanium Milled Partial ☐ Acrylic Partial
☐ Valplast® Partial ☐ Complete Denture
☐ Over Denture ☐ Implant Denture

- PROCEDURE: ☐ Bite Block ☐ Custom Tray
☐ Frame Try-in ☐ Setup Try-in
☐ Acrylic Finish ☐ Valplast® Finish
☐ Reline ☐ Rebase ☐ Repair

- TEETH: ☐ Acrylic Premium ☐ Acrylic Economy ☐ Porcelain
☐ Shade _____ ☐ Mold _____ ☐ Type _____

