

las vegas **esthetics**

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Dr. _____ Date _____

Address _____

Phone _____ Email _____

Patient _____ Male

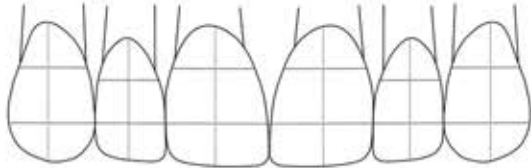
Female

Due Date* _____

*Please allow 7 lab days for composite restorations and 10 lab days for all others, including diagnostic wax-ups and orthotics.
Allow 2 additional days for shipping.

Tooth Numbers

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



Shade _____ Prep Shade _____

Value [] High [] Medium [] Low

Translucency [] Light [] Medium [] Heavy

Base Dentin = _____
Cervical Dentin = _____



Pit & Fissure Stains [] None [] Light [] Medium [] Heavy

INSTRUCTIONS

Date Received _____ Case Pan _____

Type of Restoration

Porcelain

- Empress Esthetic Crown/Veneer (cut back & Layered)
- Empress Crown/Inlay/Onlay
- E.Max Esthetic Crown/Veneer (cut back & layered)
- E.Max Crown/Inlay/Onlay
- Press to Zirconia
- Full Contour Zirconia

Composite

- Crown/Inlay/Onlay
- Post & Core

Implants

- Titanium
- Gold Hue Titanium
- Zirconia
- Cement Retained
- Screw Retained

Full Cast Metal

- High Noble
 - Gold Color
 - Silver Color
- Semi-Precious
- Non-Precious
- Post & Core

Maryland Bridges

- Composite Frame with Empress Esthetic Veneer
- E.Max
- Porcelain to Metal
- Composite
- Press to Zirconia

Orthotics/Nightguards

- Removable Neuromuscular Orthotic
- Fixed Neuromuscular Orthotic
- Nightguard
- Diagnostic Waxup

Porcelain to Metal

- Porcelain to Metal
 - High Noble (Gold Color)
 - High Noble (Silver Color)
 - Semi-Precious
 - Non-Precious
 - Captek
- Porcelain to Margin
- Buccal Porcelain Margin
- 360 Porcelain Margin
- Metal Collar
 - Lingual Only
 - 360

Uncertain - Please Call to Discuss Case

Please Send Me:
 RX's
 Boxes
 Mailing Labels

Pontic Design (circle one)



List of Items Sent

Qty	Qty	Qty
<input type="checkbox"/> Full Arch Impression _____	<input type="checkbox"/> Symmetry Bite _____	<input type="checkbox"/> Photos _____
<input type="checkbox"/> Quadrant Impression _____	<input type="checkbox"/> Opposing Model _____	<input type="checkbox"/> Previous Units _____
<input type="checkbox"/> Triple Tray Impression _____	<input type="checkbox"/> Study Model _____	<input type="checkbox"/> Implant Parts _____
<input type="checkbox"/> Bite Registration _____	<input type="checkbox"/> Diagnostic Wax-Up _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Relined Bite Stint _____		

Signature Required _____ License _____