Doctor ____________________ Phone #____________

Address ____

____

1570 42nd Street NE, Ste. 8
Cedar Rapids, Iowa 52402
Phone: (319) 378-6363
www.eclipsedentalinc.com

MY APPOINTMENT IS FOR

MONTH	DAY	TIME

Patient

First____________ Last ____________

❑ MALE ❑ FEMALE AGE______

Will opposing teeth be restored? ❑ Yes ❑ No
Do you want a metal try-in? ❑ Yes ❑ No
Will doctor trim die? ❑ Yes ❑ If needed

If prep reduction is insufficient?
❑ Reduce and mark opposing
❑ Make Reduction Coping of prep

Occlusal Contacts
❑ In occlusion
❑ Out of occlusion .3mm
❑ Out of occlusion .5mm

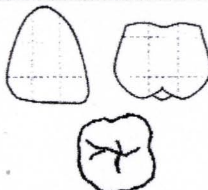
Type of Restoration
❑ All Ceramic ____________________
❑ Porcelain fused to metal
- ❑ Captek
- ❑ High Noble
- ❑ Noble
- ❑ Base Metal
- ❑ Other ____________________

❑ Full Cast ____________________ alloy

Enclosed with case

❑ impression ❑ model ❑ bite

____________ other:



Shade No. ____________

Occlusal Staining
❑ NONE ❑ LIGHT*
❑ MEDIUM ❑ DARK
*STANDARD UNLESS OTHERWISE SPECIFIED

Pontic Design

Full Ridge	Partial Ridge	Point Contact (posterior)	No Contact (posterior)	Ovate (posterior)
	*			

OFFICE USE

NOTES:

Dr. Authorization ________________________ Lisc # __________ Date ________