Doctor _____ Phone #_____

Address _____

eclipse dental

3308 Kimball Ave. Suite #4
Waterloo, Iowa 50702
319-232-6020
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

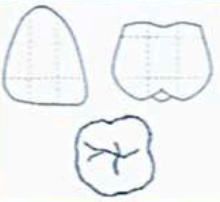
Enclosed with case

❑ impression ❑ model ❑ bite

_____ other:

Pontic Design

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



Shade No. _____

Occlusal Staining

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

OFFICE USE

NOTES:

Dr. Authorization _____ Lisc # _____ Date _____