

**Dentist Details** **Patient Details**

Name \_\_\_\_\_

Practice \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Male  Female  Age

Date & time of next appointment \_\_\_\_\_

**Wax-up Lab Requirements**

- 1 Upper & lower impressions .....
- 2 Stick-bite .....
- 3 Bite registration .....
- 4 Pre-op photos:
  - i) Full face - big smile .....
  - ii) Full face - lips at rest .....
  - iii) Close-up in occlusion .....
- 5 Facebow & bites (*only if relevant*) .....
- 6 Patient info & requirement .....

**Final Restoration Lab Requirements**

**Please send back to the lab all the models and information for the wax up requirements:**

- 1 Shade .....
  - 2 Preps impressions .....
  - 3 Provisional impression with any adjustments .....
  - 4 Notes of a future adjustment on provisional (*only where required*) .....
  - 5 Bite registration of preps to the antagonist and provisional to antagonist .....
  - 6 Relevant Photo of provisional as per wax up .....
  - 7 Type of restoration required .....
- (please tick boxes to confirm you have included items and made all necessary notes)*

**Patient Requirements**

- 01 Pressed Ceramic Veneer .....
- 02 Pressed Ceramic Crown .....
- 03 Pressed Ceramic Inlay – Onlay .....
- 04 Pressed Ceramic Post & Core .....
- 05 Pressed Ceramic Bridge .....
- 06 Zirconia Crown .....
- 07 Zirconia Bridge .....
- 08 Metal Ceramic .....
- 09 Metal Post & Core .....
- 10 Diagnostic Wax Up .....
- 11 Denar .....
- 12 .....
- 13 .....

**Further Instructions**

**Smile Design Sequence Reminder**

- |                    |                   |              |                 |
|--------------------|-------------------|--------------|-----------------|
| 1 Incisal edge pos | 3 Proportions     | 5 Gumline    | 7 Missing teeth |
| 2 Midline          | 4 Buccal corridor | 6 Embrasures | 8 Overjet       |



STAIN CHARACTERISATION  
GOLDEN PROPORTION

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Shade \_\_\_\_\_

To be taken in lab .....

**For Lab use only**

This is a custom made dental appliance that has been manufactured in accordance with the instructions specified by the prescriber for the above named client. This dental appliance is intended for exclusive use by this client and conforms to the relevant requirements specified in Annexe I of the Medical Devices Directive (93/42/EEC) and the United Kingdom Medical Devices Regulations SI 1994 No. 3017. **THIS DENTAL APPLIANCE IS NON-STERILE.**

Prescription Review: \_\_\_\_\_ Date: \_\_\_\_\_

Final Inspection: \_\_\_\_\_ Date: \_\_\_\_\_

01 02 03 04 05 06 07 08 09 10 11

**Enclosures** U  L

- Rubber Imps .....  .....
- Alginate Imps .....  .....
- Study Models .....  .....
- Bite Reg .....  .....
- Photo .....  .....