

# AestheticVision Dental Laboratory

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DR. \_\_\_\_\_

ADDRESS \_\_\_\_\_

PATIENT \_\_\_\_\_ SEX.  M  F AGE \_\_\_\_\_

RX DATE \_\_\_\_\_ DUE DATE \_\_\_\_\_ AM / PM

## TEETH 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

SMILE DESIGN: \_\_\_\_\_

SHADE: \_\_\_\_\_

PREP SHADE: \_\_\_\_\_

## INCISAL TRANSLUCENCY:

0.5mm  1.0mm  1.5mm

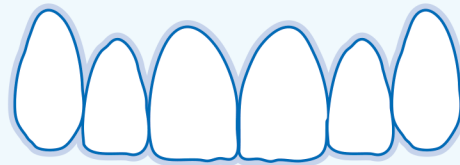
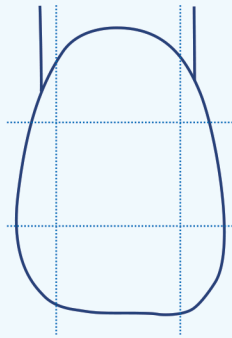
Other \_\_\_\_\_ mm

Length of #9 \_\_\_\_\_ mm

Shimbashi Measurement

(#9 CEJ to #24 CEJ) \_\_\_\_\_ mm

RIGHT \_\_\_\_\_ mm LEFT \_\_\_\_\_ mm



## SURFACE ANATOMY

Smooth

Textured: Light / Med / Heavy

Mamelon Development

Match Existing

## AMOUNT OF TRANSLUCENCY:

DESIRE IN CROWN

LIGHT  MED  HEAVY

## MATERIAL SELECTION

EMPRESS™ ESTHETIC  E.MAX®

DIAGNOSTIC WAX  SINFONY™

LAVA®

FIXED ORTHOTIC

REMOVABLE ORTHOTIC

## IF INSUFFICIENT ROOM:

Please Call

Reduction Coping

Reduce / Mark on Prep

Reduce Opposing

Call me before proceeding w/ case

## INSTRUCTIONS:

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**HAVE YOU INCLUDED THE FOLLOWING**

IMPRESSION

BITE

STICK BITE

OPPOSING

SHADE / PREP SHADE

PRE-OP MODEL

PHOTOS

MODEL OF TEMPS

DENTIST SIGNATURE: \_\_\_\_\_ LICENSE# \_\_\_\_\_

PERSON SIGNING THIS AUTHORIZATION ACCEPTS SOLE RESPONSIBILITY FOR PAYMENT.