



SPOKANE DENTAL ART

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RX DATE
DUE DATE
AM <input type="checkbox"/>
PM <input type="checkbox"/>

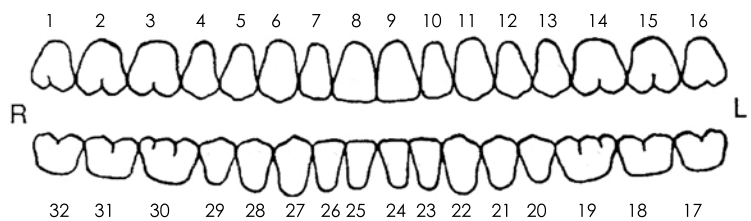
Doctor _____ Tel _____

Doctor's Address _____

Patients Name _____ Age _____ Male Female

PORCELAIN FUSED TO METAL
<input type="checkbox"/> PFM / Precious
<input type="checkbox"/> PFM / Semi-Precious
<input type="checkbox"/> PFM / Non-Precious
FULL CAST METAL
<input type="checkbox"/> FGC - Full Gold Crown
<input type="checkbox"/> Full Cast Crown
EMAX / ZIRCONIA
<input type="checkbox"/> IPS Emax <input type="checkbox"/> Zirconia Cutback
<input type="checkbox"/> Lava <input type="checkbox"/> In / Onlay
<input type="checkbox"/> Full Zirconia <input type="checkbox"/> Veneer
IMPLANT
<input type="checkbox"/> Implant Crown
<input type="checkbox"/> Custom Abutment
<input type="checkbox"/> Precious <input type="checkbox"/> Titanium <input type="checkbox"/> Zirconia
<input type="checkbox"/> Other _____

METAL DESIGN
PONTIC DESIGN
BUCCAL MARGIN
<input type="checkbox"/> Metal Hairline or _____mm on Buccal
<input type="checkbox"/> Metal-Porcelain Junction Margin
<input type="checkbox"/> Porcelain Butt Margin
CROWN SHADE
Shade _____ Stump Shade _____



REMOVABLE RESTORATIONS (Please <input checked="" type="checkbox"/>)		
DENTURES	METAL PARTIALS	SPECIALTY PARTIALS
<input type="checkbox"/> Custom Tray	<input type="checkbox"/> Standard Partial	<input type="checkbox"/> Acrylic Partial Flipper
<input type="checkbox"/> Base Plate/Wax Rim	<input type="checkbox"/> Frame Try-In	<input type="checkbox"/> Acrylic Partial w/ Clasp
<input type="checkbox"/> Combo Tray w/ Wax Rim	<input type="checkbox"/> Wax Try-in with Teeth	<input type="checkbox"/> Unilateral (NESBIT)
<input type="checkbox"/> Overdenture	<input type="checkbox"/> Bite Block	<input type="checkbox"/> Metal / Acrylic
<input type="checkbox"/> Premium Denture	<input type="checkbox"/> Finish	SPECIALTY PRODUCTS
<input type="checkbox"/> Transitional Denture	FLEXIBLE PARTIALS	<input type="checkbox"/> Talon Nightguard
<input type="checkbox"/> Immediate Denture	<input type="checkbox"/> Valplast™	<input type="checkbox"/> Hard Clear Nightguard
<input type="checkbox"/> Denture Set-Up	<input type="checkbox"/> Valplast™ Repair	<input type="checkbox"/> Proform Nightguard
<input type="checkbox"/> Denture Finish	<input type="checkbox"/> Valplast™ Rebase	<input type="checkbox"/> Bleaching Tray
REPAIRS / RELINES	<input type="checkbox"/> Set-Up	<input type="checkbox"/> Vacuum Nightguard
Relines	<input type="checkbox"/> Finish	<input type="checkbox"/> TAP Snoring Appliance
<input type="checkbox"/> Hard <input type="checkbox"/> Soft	SHADE	<input type="checkbox"/> Sportsguard
Repairs	Acrylic	<input type="checkbox"/> Band & Loop Appliance
<input type="checkbox"/> Tooth <input type="checkbox"/> Fractures	<input type="checkbox"/> Lucitone <input type="checkbox"/> Pink	<input type="checkbox"/> Lingual Arch
<input type="checkbox"/> Clasp	<input type="checkbox"/> Deluxe <input type="checkbox"/> Meharry	<input type="checkbox"/> Space Maintainer
Note _____	<input type="checkbox"/> Economy	<input type="checkbox"/> Hawley Retainer
	<input type="checkbox"/> Dark	<input type="checkbox"/> Clear Aligner
	Tooth Shade _____	<input type="checkbox"/> Twin Block
	Tooth Mold _____	

RX Specific Instructions



Dr. Signature _____

License No. _____