UNICE
Dental Art Ltd.

Digital Surgical Guide Rx Form

Doctor's Name: ______________________ Office Name: ______________________

Patient Name: ______________________ Return Date/Time: ______________________

Dr's Preferred Contact: ☐ Secure E-Mail: ______________________ ☐ Phone: ____________

Guide Type: ☐ Implant Placement ☐ Bone Reduction ☐ Fully Guided ☐ Pilot Guided

CBCT Sent by: ☐ CD/USB ☐ Secure E-Mail ☐ DDX ☐ Other: ______________________

CBCT Sent Date: ______________________

Models: ☐ Impression/Model ☐ I/O Scan ☐ Dual Scan ☐ Diagnostic Model/Wax-up/Digital

Model Sent Date: ______________________

Preferred Implant System: ______________________

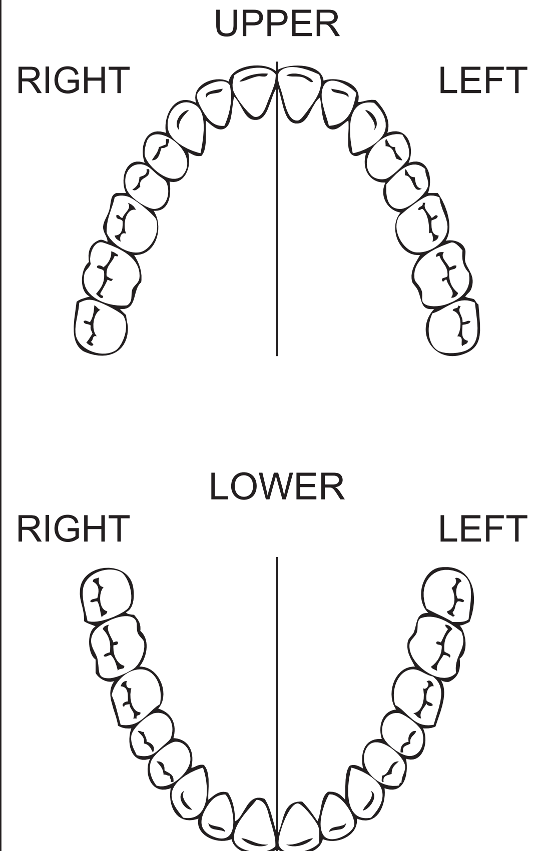
Rx_

☐ Grafting/Sinus Lift Planned

☐ Immediate Temp. Restoration

Implant Sites: (Please list tooth numbers here, ______________________

or select teeth on diagram below) ______________________



235 17th Avenue SE Calgary AB T2G 1H5
Toll Free: 1.866.939.2515 Fax: 403.277.2518

Doctor's Signature ______________________