Sun
DENTAL LABS
1800 9th Avenue North
St Petersburg, FL 33713
1.866.561.9777
Fax 727.573.1151
sundentallabs.com

Doctor's Name/Account Number of Referring Dental Lab:____________________

____

Address____

City______________________________ State_________ Zip______________

Phone______________________________ Fax ____________________________

Email____

Patient's Name ____

Date of RX _____/_____/_____ **Requested Return Date** _____/_____/_____

LAB USE

☐ Impression(s)	☐ Articulator	☐ Pymt
☐ Parts in Imp	☐ Loose Parts	☐ Other __________
☐ Model(s)	☐ Bite Reg	☐ Cases
☐ Parts in Model	☐ Crown	

IMPLANT INFORMATION			ABUTMENT TYPE (CHOOSE ONE PER IMPLANT)		RESTORATION RETENTION (CHOOSE ONE PER IMPLANT)		RESTORATION TYPE (CHOOSE ONE PER IMPLANT)						SHADING
Tooth #	Implant Brand	Size	Titanium*	Zirconia Hybrid	Cemented*	Screw Retained	Zirconia Full*	Zirconia Layered	e.max	NP PFM	SP PFM	HN PFM	Shade
			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
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			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

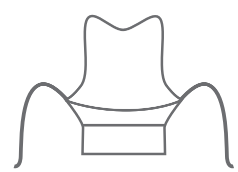
MARGIN INFORMATION

B/F 1.5mm*	
D .5mm*	
M .5mm*	
L .5mm*	

☐ USE DEFAULTS

EMERGENCE INFORMATION

☐ Surgical Placement
☐ Tissue Displacement* (.2mm displacement)
☐ No Tissue Displacement



CHECKLIST–PLEASE SEND WITH CASE

☐ This prescription form
☐ Bite registration
☐ Articulated master cast with soft tissue and analogs placed

or

☐ Impression with Transfer copings and opposing model

SPECIAL INSTRUCTIONS:

Doctors Signature REQUIRED | **License Number** REQUIRED

**DENOTES DEFAULT*

TECH05262016