

CBI Dental Prosthetics

Dental Laboratory

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 Fredericksburg, VA 22405
 Phone: 800-761-4182
 Direct: 617-827-1282
info@cbidp.com
www.cbidp.com

Rx DATE _____ DELIVER BY 5:00PM ON _____

DOCTOR'S NAME _____ (PLEASE PRINT)

DOCTOR'S ADDRESS _____ PHONE _____

PATIENT'S NAME (Last Name, First Name) _____ Sex _____ AGE _____

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

PHOTOS INCLUDED: UPLOADED ONLINE NO

IF INSUFFICIENT ROOM:
 Please Call Reduction Coping Reduce & Mark

FABRICATION PURPOSE: Correct Malalignment Close Spaces
 Increase Length Color Change

SURFACE TEXTURE: Smooth Moderate Heavy

Fixed- METAL - FREE

e.max e.max Ultra Capital Zi Esthetic™ (layered zirconia)
 Complete Z™ (full-contour zirconia) Complete Z Ultra™ (premium option)

Fixed- METAL

PFM ALLOY: (Circle Alloy Color) High Noble Yellow/White (precious) Noble (semi-precious)
FULL CAST ALLOY: (Circle Alloy Color) High Noble Yellow/White (precious) Noble Yellow/White (semi-precious)

METAL DESIGN:
 BAND AT BUCCAL: Hair Line 1 mm 2 mm No metal exposed
 BAND AT LINGUAL: Hair Line 1 mm 2 mm No metal exposed

PONTIC DESIGN:

Saddle Ridge Lap Conical Modified Ridge Lap Ovate

TRY-IN: Framework Bisque

BUTT JOINTS: 180° 360°

SHADING CHART

Shade of Prepared Teeth: _____ Shade Desired: _____ Anterior Expert Shade System® Photos Sent

Value:
 High (bright)
 Medium
 Low

Occlusal Stain:
 None
 Light
 Medium
 Heavy

Hypo-Calci-fication _____ Posterior Occlusal Characterization _____

Removables

CAST PARTIALS:
 FREE Survey/Design Casting Try-In Acetal Clasp
 Biteblock Set-Up/Try-In Flex Clasp (clear or pink)

DENTURE:
 Custom Tray Try-In Reline Bioform IPN
 Biteblock Finish Rebase BlueLine
 Set-Up Repair Soft Liner Portrait
 Economy Porcelain

Shade: Ant. _____ Post. _____
 Mould: Ant. _____ Post. _____

ACRYLIC: Regular Flexible Partial SR-Ivocap
FINISH: Smooth Characterized

NIGHTGUARDS:
 Intelliform™ SafeGuard™ Hard SafeGuard™ Hard/Soft Hard/Soft Nightguard

ATHLETIC GUARDS:
 Multi-color (strap included) Clear Vinyl

DESIGN YOUR CASE HERE:



CASE INSTRUCTIONS

Known Patient Allergies: _____

FOR LAB USE ONLY:



Attention: _____
 Call Me Please evaluate my work
 Please Send: Rxs Shipping labels Boxes

SIGNATURE OF DENTIST _____ License # _____