Kinder Krowns® Rx

Laboratory Procedure Prescription

OFFICE INFORMATION

Doctor Name _____

Practice Name _____

Address _____

City _____ State _____ Zipcode _____

Office Phone _____

Cell Phone _____

CASE INFORMATION

Patient Name _____

Gender ☐Male ☐Female

RX Date _____ Next Appt. _____

Standard working time will be used if no date is given.

*Case turnaround times are based on the date the RX is received at our lab. Please allow a minimum of 10 business days in lab processing time.

CASE INSTRUCTIONS

☐ **Patient Specific Zirconia Restoration**

Digital Impression Sent

☐Yes ☐No

Impression Enclosed

☐Yes ☐No

Tooth Shade _____

☐ **Modified Zirconia Kinder Krown®**

Tooth Letter _____

Desired Measurements

Mesial/Distal _____mm

Buccal/Lingual _____mm

Height _____mm

More than one crown? Add measurements under additional information.

Tooth Shade _____

☐ **Pedo Bridge (Groper)**

Tooth Shade _____

Gauge Wire _____

.8mm is standard

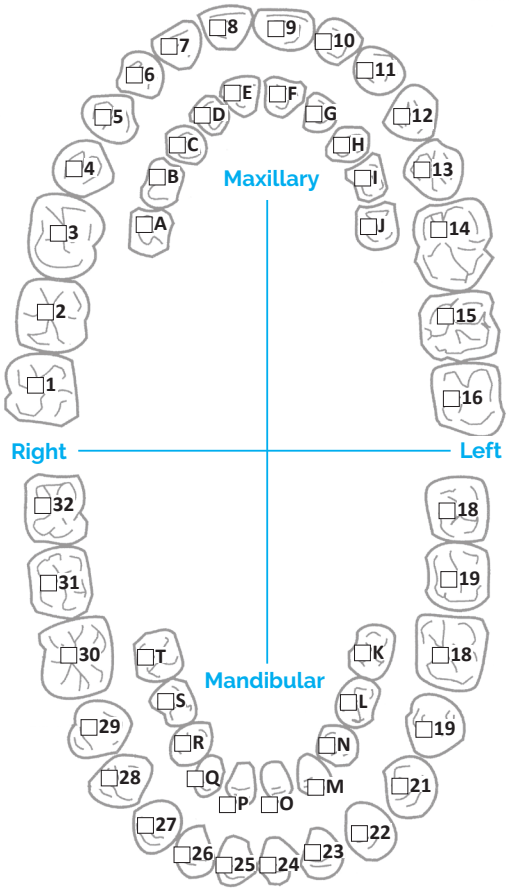
☐ **Patient Specific Crown Matrix Form**

Digital Impression Sent

☐Yes ☐No

Impression Enclosed

☐Yes ☐No



Additional Information:

Dentist Signature _____

Dentist License Number _____

7505 Highway 7, Suite 100 | St. Louis Park, MN 55426 | 877-557-6967 | custserv@kinderkrowns.com | www.KinderKrowns.com | DL: 121095-00