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

Patient Age ______________

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

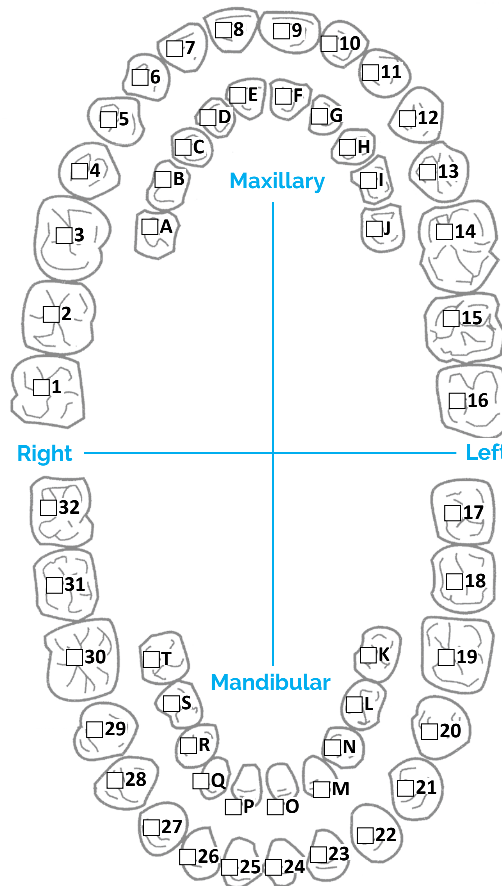
☐ **Patient Specific Crown Form Matrix**

Digital Impression Sent

☐Yes ☐No

Impression / Model Enclosed

☐Yes ☐No



Additional Information:

Dentist Signature ______________________________

By keying in your name, you are digitally signing this document.

Dentist License Number ______________________________

Terms: Net 30 with a service charge of 1.5% per month on charges over 30 days after statement date. Only if signed, construct and deliver the herein described dental restoration(s). Client shall be responsible for all fees, costs, charges, and expenses expended or incurred in any suit or action for collection of paste due amounts or enforcement of provisions of this Agreement.