

Kinder Crowns® 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 Crown®

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

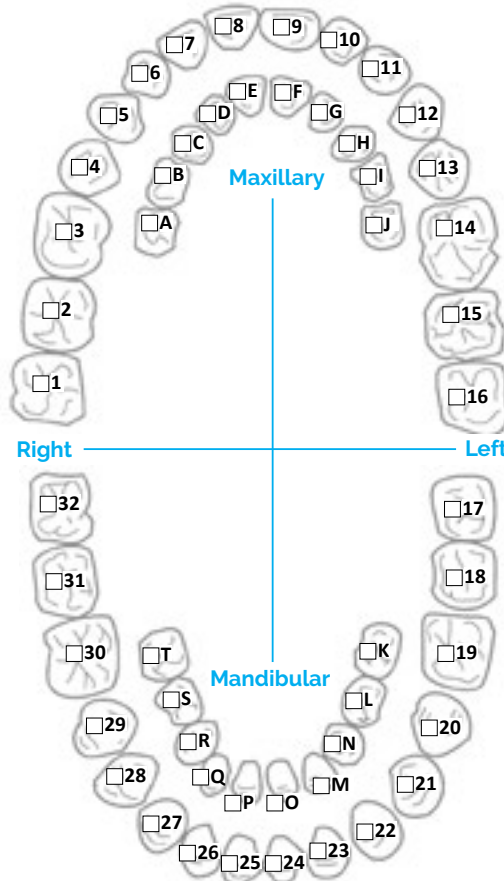
Digital Impression Sent

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.