



Lab \_\_\_\_\_

Phone \_\_\_\_\_

**Due Date**  
By 5pm

**Shade**

411 W Lambert Rd.  
Ste 405, Brea, CA 82821  
T. 949 . 356 . 3193

bluetoothdentalsolution@gmail.com

Patient \_\_\_\_\_ / \_\_\_\_\_

Last

First

<b>IF NO OCCLUSAL CLEARANCE</b> <input type="checkbox"/> REDUCE PREP <input type="checkbox"/> SPOT OPPOSING <input type="checkbox"/> CALL THE LAB* <i>*If blank, default values will be used</i>	<b>BITE</b> <input type="checkbox"/> OUT OF OCCLUSION <input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM* <input type="checkbox"/> TIGHT	<b>CONTACT</b> <input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM* <input type="checkbox"/> TIGHT	<b>OCCLUSAL STAINING</b> <input type="checkbox"/> NONE* <input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM <input type="checkbox"/> DARK
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### ALL CERAMIC RESTORATIONS

	Finish	No Glaze
Full Zirconia Crown . . . . . <i>Preshade</i>	<input type="checkbox"/>	<input type="checkbox"/>
Full Zirconia Esthetic Crown . . . . . <i>Multi Layered</i>	<input type="checkbox"/>	<input type="checkbox"/>
Zirconia Coping . . . . . <i>Preshade</i>	<input type="checkbox"/>	<input type="checkbox"/>

*\*Additional design request fee may apply*

### ABUTMENT & IMPLANT BAR

Titanium Abutment . . . . .

Gold Hue Titanium Abutment . . . . .

Zirconia Abutment w/Ti-Base . . . . .

Implant Bar. . . . .


Please Indicate Bar Design :

### SCREW RETAINED CROWN


*\*Include Custom Designed Ti-Base*

	Finish	No Glaze
Full Zirconia . . . . . <i>Preshade</i>	<input type="checkbox"/>	<input type="checkbox"/>
Full Zirconia Esthetic . . . . . <i>Multi Layered</i>	<input type="checkbox"/>	<input type="checkbox"/>
Angulated Screw Channel (ASC) Crown . . . . . <i>Multi Layered</i>	<input type="checkbox"/>	<input type="checkbox"/>


### ABUTMENT EMERGENCE PROFILE



Contour Tissue\*



Tissue Displacement



No Tissue Displacement

**Design Confirmation :**     Yes     No

**If yes, :**     By Email     By Text message

email/ cell # \_\_\_\_\_

### ABUTMENT MARGIN DEPTH

\_\_\_\_\_

Facial



\_\_\_\_\_

Mesial

\_\_\_\_\_

Lingual

\_\_\_\_\_

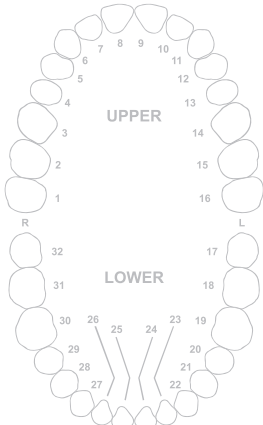
Distal

*\*Default 0.5mm Subgingival All Around    \*If blank, default values will be used*

Rx Implant System \_\_\_\_\_ Implant Diameter \_\_\_\_\_ mm

*\* If you need to send us any photographs regarding cases, please send them to our email or by text message.*

ALL RESTORATIONS  
MADE IN USA



TERMS: Cost of collection of any account will be paid by the customer. All accounts are payable within 30 days of statement date. Accounts not paid within the stated terms will be subject to COD status and a late charge of 3 percent of the unpaid balance. Prices subject to change without notice. Rx must be enclosed with original case submission.