Beautiful Anteriors

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"They Drop Right In"

ANTERIOR SMILE DESIGN FORM

Patient ______________________________ Date ____________

❑ Male ❑ Female Age ________ Photos Enclosed or e-mailed _______

Shade ___________ Prep Shade ___________ Tooth Numbers ______________

CHECKLIST

BEFORE PREPARATION

1. Pre-op Model or Impression ❑
2. Full Face Photo of Smile ❑
3. Close up with Shade Guide ❑
4. Desired Shade ❑
5. Clear Opposing Model or Impression ❑

AFTER PREPARATION

1. Clear Master Impression ❑
2. Photo of Preps with Shade Guide ❑
3. Bite ❑
4. Completed Work Order ❑
5. Material Selection
   E-max ❑ Zirconia ❑

Additional Instructions
Patient / Doctor's Goal

Signed Dr. ______________________________

Address ______________________________

City __________________ State _____ Zip __________

Please send: ❑ Prescription Forms ❑ Labels ❑ Boxes

Please Schedule Patient
2 Days After Due Date

DATE REQUESTED

ACTUAL APPT.
Date Time