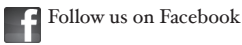




843-554-4246 voice  
 843-554-4607 fax  
 shadesSC@absolutedentalservices.com  
 absolutedentallab.com  
 License SCDLA268



PREP DATE: \_\_\_\_\_

DATE NEEDED: \_\_\_\_\_

SPECIFY TIME NEEDED: \_\_\_\_\_

*(Please follow our monthly delivery schedule)*

DR: \_\_\_\_\_ PATIENT: \_\_\_\_\_

<b>TEETH</b>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
<b>NUMBERS</b>	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
<b>DIGITAL IMPRESSION</b> <input type="checkbox"/>		<b>SYSTEM USED</b> _____															
<b>METAL FREE</b>		<input type="checkbox"/> LAB TO USE BEST MATERIAL FOR STRENGTH AND ESTHETICS <input type="checkbox"/> ENVISION ZIRCONIA <input type="checkbox"/> ENVISION VENEER/INLAY <input type="checkbox"/> ADZIR ZIRCONIA <input type="checkbox"/> E*MAX VENEER/INLAY <input type="checkbox"/> E*MAX DISILICATE <input type="checkbox"/> FELDSPATHIC VENEER															
<b>PFM ALLOY TYPE</b>		<input type="checkbox"/> POSTERIOR FLAT RATE NOBLE PFM - ONLY SINGLE UNITS <input type="checkbox"/> WHITE NOBLE <input type="checkbox"/> YELLOW HIGH NOBLE <input type="checkbox"/> WHITE HIGH NOBLE <input type="checkbox"/> BASE / NON-PRECIOUS															
<b>PFM MARGIN TYPE</b>		<input type="checkbox"/> LINGUAL METAL COLLAR SHOW NO METAL ON FACIAL <input type="checkbox"/> 360° SHOW NO METAL <input type="checkbox"/> FACIAL PORCELAIN BUTT <input type="checkbox"/> 360° METAL COLLAR <input type="checkbox"/> LING. SCALLOP DESIGN															
<b>SPECIALTY CASES</b>		<input type="checkbox"/> METAL OCCLUSAL <input type="checkbox"/> EXISTING PARTIAL <input type="checkbox"/> SURVEY CROWN <input type="checkbox"/> CROWN WITH REST															
<b>FULL CAST CROWNS</b>		<input type="checkbox"/> POSTERIOR FLAT RATED NOBLE FULL CAST YELLOW <input type="checkbox"/> 40% YELLOW GOLD <input type="checkbox"/> NON-PRECIOUS YELLOW GOLD <input type="checkbox"/> 60% YELLOW GOLD <input type="checkbox"/> WHITE NOBLE ALLOY <input type="checkbox"/> 80% YELLOW GOLD <input type="checkbox"/> WHITE HIGH NOBLE ALLOY															
<b>IMPLANT PLATFORM</b>		<b>COMPANY:</b> _____										<b>IMPLANT SIZE:</b> _____					
<b>PATIENT INFO</b>		<input type="checkbox"/> SHADE PICS SENT TO shadesSC@absolutedentalservices.com <input type="checkbox"/> PATIENT TO CALL LAB <input type="checkbox"/> MALE <b>SHADE:</b> _____ <input type="checkbox"/> FEMALE <b>AGE:</b> _____															
<b>CONTACT DDS</b>		<input type="checkbox"/> TECHNICIAN TO CALL REGARDING CASE															

SPECIAL INSTRUCTIONS: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Perfection is not optional!*

**DENTIST SIGNATURE**

**DENTIST LICENSE**

8780 Rivers Ave, Ste 206 | Charleston, SC 29406

*By signing and submitting this prescription the undersigned is agreeing to pay for the item(s) prescribed.*