



MILLCREEK UNIVERSAL CERAMICS

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Date MM/DD/YY Date Required MM/DD/YY Time _____

Doctor's Name _____

Patient's Name: Last _____ First _____ Male
 (Please Print) Female

Patient Phone No. _____ Pan# _____ Shade _____
 (For Custom Staining)

PLEASE INDICATE CASE REQUIREMENTS BELOW

Type of Crown	<input type="checkbox"/> PFM <input type="checkbox"/> e.max	<input type="checkbox"/> Full Metal <input type="checkbox"/> Full Zirconia	<input type="checkbox"/> Implant <input type="checkbox"/> Layered Zirconia
Metal	<input type="checkbox"/> Yellow High Gold	<input type="checkbox"/> White High Gold	<input type="checkbox"/> Semi-Precious <input type="checkbox"/> Non-Precious
Occlusion	<input type="checkbox"/> Metal/Zirconia	<input type="checkbox"/> Porcelain	<input type="checkbox"/> Metal/Zirconia Island
Labial Margin	<input type="checkbox"/> Fine Metal Collar	<input type="checkbox"/> Porcelain Butt Margin	<input type="checkbox"/> Zero Metal Margin
Lingual Margin	<input type="checkbox"/> Fine Metal Collar	<input type="checkbox"/> Zero Metal Margin	
Occlusal Contact	<input type="checkbox"/> Positive	<input type="checkbox"/> Foil Relief	<input type="checkbox"/> # of Foils _____
Contact	<input type="checkbox"/> Broad 	<input type="checkbox"/> Normal 	<input type="checkbox"/> Point 
Pontic Design	<input type="checkbox"/> Hygienic 	<input type="checkbox"/> Saddle 	<input type="checkbox"/> Ridgelap  <input type="checkbox"/> Sanitary 

Will opposing teeth be restored? _____ YES NO _____

OK to relieve opposing? _____ YES NO _____

OK to relieve prep? _____ YES NO _____

Metal bite stop OK? _____ YES NO _____

