S: _____

G: _____

B: _____

I: _____

☐ Photo
☐ E-Mail

Stump _____

Ingot _____

Transfer Die _____

☐ Tissue

☐ Scanned
☐ Milled
☐ Zircon Coping
☐ E-Max Cad
☐ Reduct Coping

DR: _____ **CN:** _____

PT: _____ **DD:** _____

TJ: _____ ☐ _____

BJ: _____ ☐ _____

☐ Ground
☐ 2-Day
☐ NDA
☐ Int'l
☐ In NDA
☐ **No 197**

SPECIAL INSTRUCTIONS

Signature of Dentist **Date** **License #**

WILLIAMS DENTAL LABORATORY

STANDARD PRESCRIPTION

7510 Arroyo Circle
Gilroy, CA 95020
Toll Free: (800) 713-5390
Fax: (408) 842-5002
www.williamsdentallab.com

DOCTOR INFORMATION	PATIENT INFORMATION
Doctor: _____	Last Name: _____
Address: _____	First Name: _____
City, St, Zip: _____	Sex: _____
Phone: ( ) - _____	Age: _____
E-Mail: _____	Patient's Appt Date/Time: _____

Return by 5pm On: _____

Type of Restoration	Indicate Teeth Number(s)/Arch
☐ Diagnostic Wax-Up	
☐ LVI Fixed Orthotic	
☐ Removable Neuromuscular Orthotic	
☐ Emax	
☐ Empress	
☐ Feldspathic	
☐ Zirconium	
☐ Cristobal / Belle / Sinfony	
☐ Porcelain to Metal	
☐ Full Cast Gold	
☐ Implant	
☐ Future Partial	
☐ Other _____	

Occlusal Surface	Buccal Margins	Type of Metal	
☐ Metal	☐ Feather Margin	☐ Non-Precious	☐ High Noble White
☐ Porcelain	☐ Metal Band	☐ Semi-Precious	☐ High Noble Yellow
	☐ Porc Butt Shoulder	☐ Titanium	

Opposing Teeth to be Restored: ☐ Yes ☐ No ☐ Relieved

SHADE & CHARACTERIZATION CHARTING

Gingival: _____
Body: _____
Incisal: _____
Stump: _____

Central Length MM

Checklist

___ U/L Impressions	___ Relined Bite Stent	___ Call Before Proceeding
___ U/L Models	___ Photos	___ Send Prescriptions
___ Opposing Models	___ Shade	___ Send Mailing Labels
___ Approved Temp Models	___ Smile Design	___ Disinfect Every Case
___ Diagnotic WaxUps	___ Horizontal Reference	___ Other _____
___ Bite(s)	___ Manage the Bite Form	