

# Cosmetic RX

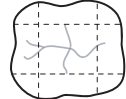
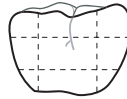
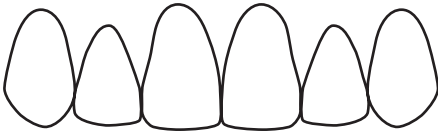
METAL TRY-IN
BISQUE TRY-IN
FINISH

Dr. \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

Patient \_\_\_\_\_

Gender:  Male  Female Age: \_\_\_\_\_

Shade: \_\_\_\_\_ Stump Shade: \_\_\_\_\_



**Type of restoration desired:** \_\_\_\_\_ **Teeth to be restored:** \_\_\_\_\_  
 (see restoration options sheet for various choices)

## CHARACTERIZATION CHART (select from laminated characterization guide)

### ANTERIOR

- Translucency Intensity  TI-1  TI-2  TI-3  
 Translucency Volume  TV-4  TV-5  TV-6  
 Lobing  L-7  L-8  L-9  
 Texture  T-10  T-11  T-12  
 Glaze  Low  Med  High

### POSTERIOR OCCLUSAL

- Stain Placement  SP1  SP2  SP3  SP4  
 Stain Color  SC5  SC6  SC7  SC8  
 White Cusp Levels  WC9  WC10

## REASON FOR RESTORATION

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> ALIGNMENT    | <input type="checkbox"/> SHADE CHANGE     | <input type="checkbox"/> LENGTHEN TEETH |
| <input type="checkbox"/> RECONTOURING | <input type="checkbox"/> FEMINIZE SMILE   | <input type="checkbox"/> CHANGE SHAPE   |
| <input type="checkbox"/> TETRACYCLINE | <input type="checkbox"/> DIASTEMA CLOSURE | <input type="checkbox"/> MOVE MIDLINE   |
| <input type="checkbox"/> OTHER _____  |   |   |

**\* Please provide pictures with the case \***

Other Notes:

This is your authorization pursuant to the provisions of Article II of the Dental Practice Act of the State of California to construct, alter, or repair the dental restoration described here on.

Dr.'s Sig. \_\_\_\_\_

Lic. # \_\_\_\_\_