

Cosmetic RX

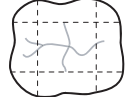
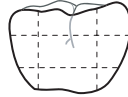
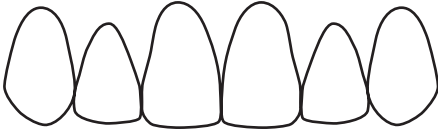
METAL TRY-IN
BISQUE TRY-IN
FINISH

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

- ALIGNMENT
- RECONTOURING
- TETRACYCLINE
- OTHER _____
- SHADE CHANGE
- FEMINIZE SMILE
- DIASTEMA CLOSURE
- LENGTHEN TEETH
- CHANGE SHAPE
- MOVE MIDLINE

*** 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. # _____