MagellanDentalArts **HIGH**ESTHETIC™

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HIGHESTHETIC™ RESTORATIONS ARE FABRICATED IN **VANCOUVER, BC**
MINIMUM DAYS REQUIRED FOR DELIVERY BACK TO DOCTORS OFFICE - **12 BUSINESS DAYS**

DR. NAME _____

ADDRESS _____

PATIENT (first & last name) _____

DUE DATE (for delivery by 5pm)

_____

FOR LAB USE

TEETH NUMBERS (please circle)

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38

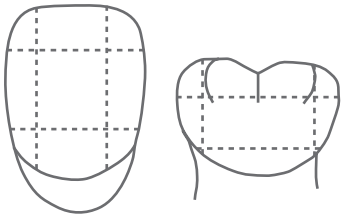
RESTORATION TYPE

- ☐ Empress®
- ☐ PFM
- ☐ Emax®
- ☐ Full Metal
- ☐ Procera® (Zirconia) Alloy: _____
- ☐ Procera® (Titanium) Occlusion: ☐ Metal ☐ Porcelain

LABIAL MARGIN

- ☐ Fine metal collar on tooth #____
- ☐ Show no metal 360°on tooth #____
- ☐ Lingual Metal Collar on tooth #____
- ☐ Porcelain Butt Margin on tooth#____

SHADE



STUMP SHADE _____

SHADE _____

VALUE + **–** _____

EMAIL DIGITAL PHOTOS TO: info@magellandental.com

INCISAL TRANSLUCENCY

- ☐ Light (1/2mm HALO)
- ☐ Medium (2/3mm HALO)
- ☐ Heavy (1mm HALO)

SURFACE ANATOMY

- ☐ Smooth
- ☐ Mamelon development
- ☐ Textured
- ☐ Match existing

PONTIC DESIGN & TISSUE RELIEF (please circle)

- ☐ Yes, mm deep____
- ☐ No

Hygienic Cone Duate Harmony Ridge Lap

OCCLUSION

- ☐ Light - 0.3 mm spacer
- ☐ Medium - 0.1 mm spacer
- ☐ Heavy – positive contact
- ☐ None ☐ Light ☐ Medium
- ☐ Dark ☐ Hypo-calcification
- ☐ Shade tab enclosed

INTERPROXIMAL CONTACTS

- ☐ Broad ☐ Normal

ANTERIOR DESIGN

- ☐ Follow Study Model
- ☐ Match Existing
- ☐ Make Ideal
- ☐ Follow Diagnostic Wax-up

MIDLINE SHIFT

R ____mm L____mm

- ☐ Close Diastema

LENGTH OF CENTRALS

____mm (from Cervical Margin of T11)

VERTICAL INDEX

Anterior ____mm Posterior ____mm

SMILE CATALOGUE SELECTION

Rx

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

- ☐ Stent(s)
- ☐ Orthotic (Fixed)
- ☐ Orthotic (Removable)
- ☐ Diagnostic Wax-up
- ☐ Acrylic Temps

INCLUDED:

- ☐ Impression
- ☐ Bite
- ☐ Opposing
- ☐ Shade
- ☐ Pre-op model
- ☐ Photos
- ☐ Model of temps
- ☐ Bite stick
- ☐ Face bow

RETURN FOR:

- ☐ Die Trim
- ☐ Metal Try-in
- ☐ Finish
- ☐ Evaluation
- ☐ Wax Check
- ☐ Bisque bake try-in

PLEASE SEND:

- ☐ Rx's ☐ Waybills
- ☐ Boxes ☐ Bags

IMPLANT CASES
Please Provide Details of Implant Type and Diameter _____

☐ Please call me about this case _____

Signature of Dentist _____ Date _____
(Person signing this authorization accepts sole responsibility for payment)

FOR OUR TERMS, POLICIES AND CONDITIONS PLEASE VISIT MAGELLANDENTAL.COM/TERMS

Top Copy: Lab
Bottom Copy: Doctor