COMPREHENSIVE IMPLANT PRESCRIPTION FORM

DOCTOR NAME: _____ DATE: _____

☐ Signature and License Number on File

ADDRESS: _____

_____

PHONE: _____ FAX: _____

PATIENT NAME: _____

Return dates are determined after a case review based on the complexity and doctor/technician collaboration required.

☐ Please call for consultation (required for all complex cases)

FINAL RESTORATION PLAN

☐ CEMENTED RESTORATION (abutment final torque, then crown cemented intraorally)

☐ SCREW RETAINED:
- ☐ 1-piece UCLA | PFM
- ☐ 1-piece (lab cements crown on abutment)
- ☐ 2-piece (clinician cements crown on abutment)

ABUTMENT TYPE

STOCK	CUSTOM MILLED	UCLA	TI-BASE
☐ Titanium ☐ Metal only ☐ Opaqued ☐ Zirconia	☐ Titanium ☐ Metal only ☐ Opaqued ☐ Zirconia	☐ Metal only ☐ Opaqued ☐ with Ceramic	☐ Pressed Lithium Disilicate Abutment ☐ Zirconia Abutment ☐ Implant Brand Specific ☐ Third Party Components OK

ABUTMENT/CROWN MARGIN POSITION

FIRST IMPLANT SITE #	EQUIGINGIVAL	SUPRAGINGIVAL	SUBGINGIVAL
Labial	☐ Yes	☐ _____mm	☐ _____mm
Interproximal	☐ Yes	☐ _____mm	☐ _____mm
Lingual	☐ Yes	☐ _____mm	☐ _____mm

*For multiple implant sites, if different for each implant, please complete additional charts located at the end of the prescription form.

ADDITIONAL INFORMATION: _____

_____

_____

_____

_____

IMPLANT INFORMATION

Implant brand(s): _____

Implant size(s): _____

Implant site(s): _____

☐ Use only manufacturer specific restorative components **OR**

☐ Third party components acceptable (not available for all brands)

IMPLANT PARTS
(one of the following 2 required)

☐ Custom Impression Post
- ☐ Master Cast – do not alter tissue on cast
- ☐ Master Cast - lab to alter tissue contour as necessary

☐ Stock Impression Post
- ☐ Master Cast – do not alter tissue on cast
- ☐ Master Cast - lab to alter tissue contour as necessary

☐ Office sending (in addition to one of the above):

☐ Lab to order parts

NOTES: _____

_____

_____

_____

SCREW RETAINED: ☐ Y ☐ N

If yes:
- ☐ Splint final restorations
- ☐ Single unit final restorations planned

PINK CERAMIC ANTICIPATED:
- ☐ On abutment
- ☐ On restoration
- ☐ Technicians' preference
- ☐ Prescribed pink shade (required): _____
  - ☐ Pink shade tab photos included

LEVEL OF SERVICE (Final Restorations)

☐ **EXPRESS** (monolithic, stained & glazed)

Material/Indicate Tooth Number(s): _____
- ☐ Monolithic pressed lithium disilicate (LD)
- ☐ Monolithic translucent zirconia (4Y-ZP)
- ☐ Monolithic opacified zirconia (3Y-TZP)

☐ **CLASSIC**

Material/Indicate Tooth Number(s): _____
- ☐ Monolithic pressed lithium disilicate (LD)
- ☐ Layered pressed lithium disilicate (LD)
- ☐ Monolithic translucent zirconia (4Y-ZP)
- ☐ Monolithic opacified zirconia (3Y-TZP)
- ☐ PFZr (3Y-TZP zirconia substrate)
- ☐ PFM (Complete substrate information*)

☐ **ULTIMATE** (Master ceramist)

Material/Indicate Tooth Number(s): _____
- ☐ Monolithic pressed lithium disilicate (LD)
- ☐ Layered pressed lithium disilicate (LD)
- ☐ Monolithic translucent zirconia (4Y-ZP)
- ☐ Monolithic opacified zirconia (3Y-TZP)
- ☐ PFZr (3Y-TZP zirconia substrate)
- ☐ PFM (Complete substrate information*)

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*PFM METAL SUBSTRATE

- ☐ Nobel (25% Pd)
- ☐ High Nobel (51% Au)
- ☐ Metal occlusal with buccal ceramic:
- ☐ Metal coping with full ceramic coverage:
  - ☐ Metal collar: ☐ 180° ☐ 360°
  - ☐ Ceramic to edge of metal:
  - ☐ Ceramic margins ☐ 180° ☐ 360°

BRIDGE PONTIC DESIGN

- ☐ OVATE
- ☐ MODIFIED RIDGE LAB
- ☐ RIDGE LAP
- ☐ ADJUST RIDGE ACCORDINGLY
- ☐ NO RIDGE ADJUSTMENT

FINAL RESTORATION ESTHETICS

GENERAL GUIDELINES:

- ☐ Use diagnostic wax-up as guide
- ☐ Use provisional cast as guide
- ☐ Use provisional photos as guide

ANTERIOR AND POSTERIOR TEETH:

Pre-operative shade: _____
Preparation shade: _____
Requested tooth shade: _____
Requested soft tissue/gingival shade:

- ☐ Match shade tab (No photographs provided)
- ☐ Match per photos (Suggested photos - Photographs of shade tab next to tooth and next to preparation)
- ☐ Occlusal Staining
  - ☐ None
  - ☐ Slight
  - ☐ Natural

ANTERIOR TEETH SHADE INFORMATION:

- ☐ All teeth same color and value
- ☐ Cuspid one shade more chromatic than central

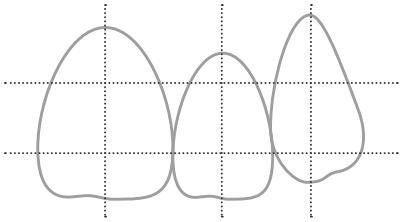
Incisal translucency:

- ☐ None
- ☐ Slight
- ☐ Natural

Layering (Classic and Ultimate Only): tooth number(s)_____

- ☐ Facial/buccal only (maximum strength):
- ☐ 50% incisal edge:
- ☐ 100% incisal edge (maximum esthetics)

DRAW REQUESTED SHADE MAPPING
Optional



HORIZONTAL REFERENCE

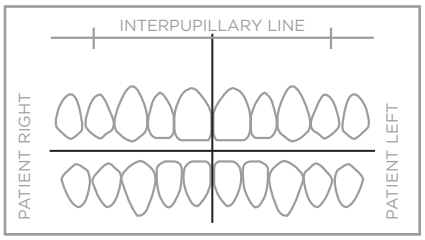
- ☐ Y ☐ N Use interpupillary line that parallels horizon – if NO, other reference:
- ☐ Y ☐ N Use facebow or other maxillary transfer device to determine horizontal plane
- ☐ Y ☐ N Maxillary incisal plane parallels horizon – If NO
  - ☐ Patient's right side is high
  - ☐ Patient's right side is low
- ☐ Y ☐ N Mandibular incisal plane parallels horizon – If NO
  - ☐ Patient's right side is high
  - ☐ Patient's right side is low
- ☐ Y ☐ N Maxillary midline is perpendicular to incisal plane. If NO (canted):

Communicate the deviation w/ horizontal with:

- ☐ Diagram below ☐ Photograph
- ☐ Facebow mounting

Draw with dashed line current midline & incisal plane relative to horizon and vertical lines

- ☐ Correct midline cant and incisal plane to match horizontal and vertical lines



- ☐ No reference provided: Use best technical judgment

DESIRED MAXILLARY RIGHT CENTRAL INCISAL EDGE (Tooth #8)

Position relative to current position:

- ☐ Y ☐ N Change incisal length. If YES:
  - ☐ Shorten by: _____ mm
  - ☐ Lengthen by: _____ mm
- ☐ Y ☐ N Technician may determine based on information provided

DESIRED MANDIBULAR INCISOR EDGE POSITION

Position relative to current position:

- ☐ Y ☐ N Change incisal length. If YES:
  - ☐ Shorten by: _____ mm
  - ☐ Lengthen by: _____ mm
- ☐ Y ☐ N Technician may adjust length to establish desired function if not included in diagnostic wax-up (+/-)

ADDITIONAL ESTHETIC INFORMATION

Maxillary lateral incisor shorter than central by: _____ mm
Maxillary incisal edges:
☐ Natural ☐ Flat
Maxillary incisal embrasures:
☐ Natural ☐ Closed (square)
Widen buccal corridor: ☐ Y ☐ N
Close gingival embrasures: ☐ Y ☐ N
Close diastema: ☐ Y ☐ N

OCCLUSAL / FUNCTIONAL CONSIDERATIONS

- ☐ Refer to client preferences
- ☐ Case specific effects (see below)

• Mount maxillary cast with device relative to horizon

- ☐ Facebow
- ☐ Kois transfer
- ☐ Bite stick (does not relate and transfer A-P occlusal plane)
- ☐ Arbitrarily mount the cast leveling the maxillary incisal and occlusal planes

• Mount mandibular cast with:

- ☐ CR record:
  - ☐ 1 record enclosed - assume it is accurate
  - ☐ 2 records enclosed - 2nd used to confirm accuracy. If records do not coincide:
    - ☐ Contact Dr. to determine course of action
    - ☐ Proceed with 1st mounting record
  - ☐ Clinical first point of contact (REQUIRED): Teeth #s
- ☐ Return for trial equilibration by Dr. (technician will not perform equilibration)
- ☐ All occlusal contacts to be determined by wax-up
- ☐ Hand articulation of casts in MIP (or with wax bite). *If a silicone bite is provided in MIP, it will not be used.*

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- Vertical dimension
  - ☐ Y ☐ N Maintain current VDO – If NO:
    - ☐ Open at incisal edges _____ mm
    - ☐ Open as needed for restorative purposes & to idealize occlusal planes *(technician can change as needed to meet esthetic and functional goals)*
- Anterior vertical overlap (overbite)
  - ☐ Y ☐ N Maintain current vertical overlap – if NO:
    - ☐ Decrease: _____ mm
    - ☐ Increase: _____ mm
- Anterior horizontal overlap (overjet)
  - ☐ Y ☐ N Maintain current horizontal overlap – if NO:
    - ☐ Decrease: _____ mm
    - ☐ Increase: _____ mm
- Anterior guidance
  - ☐ Y ☐ N Maintain original angle – if NO:
    - ☐ Decrease: _____ mm
    - ☐ Increase: _____ mm
- Lateral guidance
  - ☐ Y ☐ N Cuspid guidance
  - ☐ Y ☐ N Group function: Indicate desired tooth contacts:
- Condylar inclinations
  - ☐ Use average
  - ☐ Right: _____ degrees
  - ☐ Left: _____ degrees
- Maxillary and mandibular incisal edge design (choose one)
  - ☐ Natural
  - ☐ Flat and broad
- Tooth re-contouring
  - ☐ Y ☐ N Do not alter opposing tooth
  - ☐ Y ☐ N Adjust opposing tooth idealize form and function of wax-up

☐ Make custom incisal guide table from:
- ☐ Pre-op casts
- ☐ Provisional casts

☐ Cross-mount
- ☐ Provisional to prep

ADDITIONAL IMPLANT SITE INFORMATION (continued from page 1 if needed)

IMPLANT SITE #	EQUIGINGIVAL	SUPRAGINGIVAL	SUBGINGIVAL
Labial	☐ Yes	☐ _____mm	☐ _____mm
Interproximal	☐ Yes	☐ _____mm	☐ _____mm
Lingual	☐ Yes	☐ _____mm	☐ _____mm

IMPLANT SITE #	EQUIGINGIVAL	SUPRAGINGIVAL	SUBGINGIVAL
Labial	☐ Yes	☐ _____mm	☐ _____mm
Interproximal	☐ Yes	☐ _____mm	☐ _____mm
Lingual	☐ Yes	☐ _____mm	☐ _____mm

ADDITIONAL COMMENTS

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