POSTERIOR 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 (LD) ☐ Full Contour 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: _____

_____

_____

_____

ADJACENT IMPLANTS: ☐ 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*)

ESTHETICS BY DESIGN

PHONE: 949-899-9010 | WEB: EBDLAB.COM
17475 Gillette Ave., Suite 120, Irvine, CA 92614

*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

POSTERIOR TEETH

Pre-operative shade: _____

Preparation shade: _____

Requested tooth 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

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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