

GENERAL INFORMATION:

Doctor's Name _____
 _____ First _____ MI _____ Last _____
 Doctor's License # _____
 Practice Name _____
 Website _____
 Address _____ State _____ ZIP _____
 City _____
 Phone # _____
 Email _____

Opt in for Case Status Daily Emails

OFFICE CONTACTS FOR:

Scheduling Questions _____ Phone # _____
 Office Manager _____ Phone # _____
 Doctor's Assistant _____ Phone # _____
 Technical/Clinical Questions? _____ Phone # _____

M: __/__/__ T: __/__/__ W: __/__/__ TH: __/__/__ F: __/__/__ S: __/__/__

Emergency # _____

BILLING INFORMATION:

Main Contact _____ Phone # _____
 Name of person or company legally responsible for paying account balance:
 _____ Phone # _____
 Billing Email _____ (Billing email will only be used for statements.) Opt in for statement emails _____
 Billing Address (if Different) _____
 City _____ State _____ Zip _____

PREFERRED METHOD OF PAYMENT:

Statement Pay (Check) Statement Pay (Credit Card) COD

SPECIALTY:

General Dentist Periodontist Pediatrics/Pedodontist Cosmetic Dentistry
 Orthodontist Prosthodontist Endodontist

AFFILIATION WITH A DENTAL ORGANIZATION OR GROUP:

Smile Source Synergy DSN Other

DO YOU HAVE AN INTRA-ORAL SCANNER?

Yes No No, but interested

IF YES, WHAT KIND?

3M True Definition 3Shape Trios Cadent iTero
 DDX(Carestream/E4D) Sirona Cerec Other _____

REFERRED BY:

Website Current Customer _____
 Advertisement Word of Mouth Direct Mail Other: _____

TERMS:

The statement balance is due and payable by the fifteenth of the month following purchase. A service charge of 1.5% per month (annual rate of 18%) will be applied to any unpaid balance. Accounts with outstanding balances over 45 days will be subject to C.O.D. status. If you have any questions please contact Kathy Henley at kathy.henley@oralartsdental.com

SEE REVERSE

Doctor Preference Form

FIXED

Occlusion with a close bite:





- Call Doctor*
- Trim Opposing
- Trim Prep w/Reduction Coping
- Trim Prep w/o Reduction Coping
- Other: _____

Occlusion Options:

- Centric (0 mm out of occlusion)
- Light Centric (0.2 mm out of occlusion)
- Out of occlusion* (0.35 mm out of occlusion)
- Way out of occlusion (0.5 mm out of occlusion)

Pontic Design:

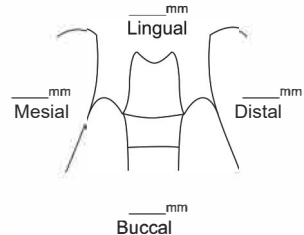
Pontics (circle preference)

 No Contact	 Modified Ridge*
 Full Ridge	 Point Contact

Other: _____

Implant Abutment Margin Depth:

Abutment Margin Depth
- Below Tissue, + Above Tissue



Lab Defaults: *




Buccal -1mm

Lingual Crest of Tissue

Interproximals -.25mm

Implant Abutment Tissue Displacement:

Abutment Emergence Profile

 Surgical Placement	 Tissue Displacement*
 No Tissue Displacement	

Other: _____

*Lab default, used if not specified

REMOVABLE

Denture Tooth Preference:

- Economy*
- Premium

Acrylic Processing:

- Lucitone 199 Acrylic*
- IvoBase Premium Injection Processing

Denture Finish:

- No Palatal Rugae*
- Stippled
- Festooning

Cast Partial Frame Design:

- Lab Design*
- Doctor Design - do not change w/o calling dr.

NightGuard Finish:

- Full Arch Coverage*
- Anterior Coverage
- Open Anterior
- Anterior Ramp