

CROWN & BRIDGE PRESCRIPTION

DR. NAME _____ ACCT. # _____

ADDRESS _____ PHONE # _____

LICENSE # _____ FAX # _____

(Patient's Last Name)

(Patient's First Name)

DATE SENT - -

DATE WANTED - -

(2 days prior to insertion)

FACE FORM Square Square Taper Taper Ovoid

CERAMIC CROWN/BRIDGE:
 _____ **Ceramic Alloy** _____

High Noble Yellow / High Noble White / Noble White

CAST CROWN/BRIDGE:
 _____ **Cast Alloy** _____

High Noble Yellow / High Noble White

 Noble Yellow / Noble White

INLAY

3/4 CROWN

MARYLAND BRIDGE

OCCLUSAL CONTACT W/OPPOSING:

Positive Contact Foil Relief

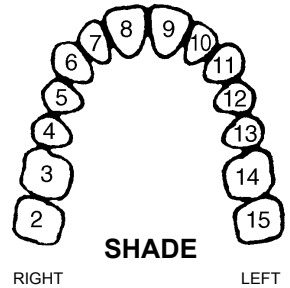
DIE SPACER: 1 coat 2 coats 3 coats

RIDGE RELIEF: None Slight Med Heavy

PONTIC DESIGN:



COMMENTS:



**FULL ARCH REQUIRED FOR 3 OR MORE UNITS
 IN ORDER TO RETAIN 5-YEAR GUARANTEE**

<input type="checkbox"/> Ortho Rx	<input type="checkbox"/> IPS Empress Rx	<input type="checkbox"/> Labels
<input type="checkbox"/> Boxes	<input type="checkbox"/> C/B Rx	<input type="checkbox"/> Price List



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