



1705 WOODLAND DRIVE EAST, SUITE 202  
 SALINE, MI 48176  
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**FIXED PROSTHETIC PRESCRIPTION**

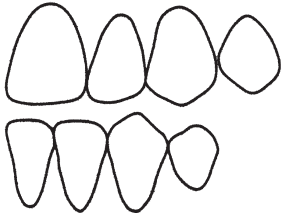
DR'S NAME \_\_\_\_\_ DR'S PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PATIENT (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

DELIVER BY Date \_\_\_\_\_ Time \_\_\_\_\_

<p><b>All Ceramic Restoration</b></p> <p><input type="checkbox"/> Porcelain Fused to Zirconia</p> <p><input type="checkbox"/> Full Zirconia    <input type="checkbox"/> Emax (Lithium Disilicate)</p> <p><input type="checkbox"/> <b>Full Cast Crown</b></p> <p><input type="checkbox"/> Yellow High Noble    <input type="checkbox"/> White High Noble</p> <p><input type="checkbox"/> Non-Precious</p>		<p><b>Implants</b></p> <p><input type="checkbox"/> Abutment    <input type="checkbox"/> Screw-Retained Crown</p> <p><input type="checkbox"/> Titanium    <input type="checkbox"/> Emax (Lithium Disilicate)</p> <p><input type="checkbox"/> Zirconia    <input type="checkbox"/> Porcelain Fused to Zirconia</p> <p><input type="checkbox"/> Full Zirconia</p>	
<p><b>If No Occlusal Clearance</b></p> <p><input type="checkbox"/> Relieve Opposing</p> <p><input type="checkbox"/> Prep Reduction Coping</p>		<p>Occlusal Stain: _____</p> <p>Texture: _____</p> <p>Stump Shade: _____</p> <p>Shade: _____</p>	



Instructions: \_\_\_\_\_

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Dentist's Signature \_\_\_\_\_ License # \_\_\_\_\_